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CONCEPTUALISING THE ROLE OF THE NURSE TEACHER IN PRACTICE SETTINGS: AN ACTION RESEARCH APPROACH

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ABSTRACT

This dissertation is a report of an action research project which was conducted in a College of Health with the aim of establishing some agreement about the responsibilities of the nurse teacher in supervising student nurses in practice settings.

The study was undertaken in the context of the introduction of Government and Statutory Nursing policies which impinge upon, and create demands upon, nurse teachers' time and commitments.

The definition of the role of the nurse teacher was explored through a literature review on role theory which provided the theoretical framework through which the questions to be posed on the role were identified. A literature review on the role of the nurse teacher revealed that there has been a persistent lack of clarity and consensus in relation to the clinical role of nurse teachers and the preparation for teachers to perform that role.

An action research approach was used to develop, in collaboration with nurse teachers and practitioners, a role for the teachers which was acceptable and workable in all practice settings in the context of constant change.

The research was conducted using Kurt Lewin's (1946) action research approach, as adopted by Kemmis & McTaggart (1988). Each spiral is made up of four areas of activity of planning, acting, observing/ evaluating and reflecting:

Planning involved clarifying with the nurse teachers their concerns in relation to the lack of role clarity in practice settings and working with them in a collaborative manner to identify the areas which needed to be explored in order to define a role for them. It also involved identifying groups of role definers and designing appropriate tools for obtaining the relevant information from them about their views on the role of the nurse teacher in practice settings. The suggested role for them which emerged from the analysis of the data was that of an educational facilitator.

Action involved taking action to change the practice of nurse teachers through working with volunteer nurse teachers as they trialled the role of an educational facilitator in one of their practice placement areas.

Observing involved designing structured diaries in which volunteer nurse teachers and practitioners were asked to record their reflections on aspects of the proposed role for nurse teachers in practice settings. The recordings in their diaries were analysed and codified by the use of Hycner's (1985) and Burnard's (1991) methodology. The "model" which has emerged from this piece of research is one which has been demonstrated as being effective in practice.

Reflecting

The role which emerged was one of preparing, supporting and guiding practitioners in support of their teaching role with student nurses. A role in which nurse teachers could bring their expertise to the practitioners in assisting them to recognise the importance of the teaching and learning aspect of their role in relation to student nurses. It also identified that the time that nurse teachers spent in practice settings would allow them to maintain and develop their professional knowledge founded on contemporary practice.

During the period which this research project was conducted, many changes took place in the College which had implications upon its course. This included amalgamation with another College of Health and integration into a University in order to form a new Faculty. My sphere of managerial responsibility therefore, changed during this process whereby I was no longer in a position to implement the findings. I therefore developed a protocol for the performance of the role in practice and presented it to the Faculty's Executive Management Group for their consideration.

The main product of the dissertation was the identification in this College of Health, of a suitable role for nurse teachers in practice as being that of an educational facilitator. The role has been evaluated as being effective in all practice settings and demonstrated enhancement of the delivery of the curriculum in practice. But it must be recognised that it is a solution based on local issues and problems, so the findings are limited in their ability to be generalised. However, an action research approach is recommended for use in other Colleges of Health who are also grappling with the same problem of identifying a role for nurse teachers in practice settings.

AUTHOR'S DECLARATION

I certify that the work on which this dissertation is based is my own independent work except where acknowledged in the text.

Signature: Date:

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GLOSSARY

CFP	Common Foundation Programme
ENB	English National Board for Nursing, Midwifery and Health Visiting
GNC	General Nursing Council for England and Wales
NHS	National Health Service
PREP	Post Registration Education and Practice
RHA	Regional Health Authority
RCN	Royal College of Nursing
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

The term practice setting is used to denote any type of placement in which student nurses gain experience during their training.

CHAPTER ONE.

INTRODUCTION

One of the responsibilities of a nurse teacher is to supervise student nurses when they undertake practice in practice settings (eg. hospital wards; nurseries; residential homes; health centres etc). Fifty percent of a student's three year training is spent in practice settings, however, the precise responsibilities of the nurse teacher in the supervision process are unclear. This is a source of anxiety for the nurse teachers and a potential source of dissatisfaction for student nurses.

This dissertation is a report of an action research project which was conducted in a College of Health with the main aim of establishing some agreement about the responsibilities of the nurse teacher in supervising students in practice settings. My initial idea was to see if a standard role specification could be produced for nurse teachers in a supervisory role.

Identification of the problem.

On taking up the post of Vice Principal Pre-Registration Nursing Studies, which included responsibility as course leader for the Diploma of Higher Education in Nursing Studies (Project 2000), I became aware from three sources that there were concerns about practice links and the role performance of the "link teacher" within those practice link areas. First, concern was being expressed by the local N.H.S. Trust managers because of the ongoing debate between the Regional Health Authority and the College over its future in relation to integration into Higher Education. The NHS Trust managers feared that when the College had integrated it would concentrate on academia to the detriment of professional practice. Therefore they were also concerned that the clinical links with them would be lost and the College would become "a centre of knowledge on the hill devoid of its practice links" (sic - as stated by one of the Chief

Nursing Advisers).

Second, written and verbal student evaluation identified their dissatisfaction with the support and supervision that some of them were receiving in some of the clinical areas from, both the practitioners and, "link teachers".

Thirdly, through my attendance at nurse teacher staff meetings and the countersigning of teachers' Individual Performance Reviews forms, I became aware that many of them were concerned, not only about the imminent move into Higher Education and the possible loss of clinical links but also about the lack of clarity of their role in clinical practice and the absence of any guidelines about how they should perform that role.

In 1990 this College established the role of the "link teacher" to coincide with the introduction of the Diploma of Higher Education in Nursing Studies programme. The course document stated:

> " a link teacher from the College is associated to all placements. This teacher is involved in the preparation and support of clinical staff acting as mentors and assessors. The link teacher is the main focus of liaison between the clinical staff and the course tutors" (A&GCOH 1990, p48).

The last part of this outline description did not appear to be totally accurate as the English National Board for Nursing, Midwifery and Health Visiting expect nurse teachers to support student nurses in practice placement settings (ENB 1993, section 2). Yet the above outline description contained no reference to this aspect of their role.

In addition, the outline role description did not appear to be accurate as, the College organises courses (a description of which is outlined on page 17) to prepare the practitioners for their

mentoring and assessing role. Therefore teachers should provide support but not to be responsible for the preparation of the practitioners. Also in this College there is no distinction between those teachers who teach in the classroom and those who teach in the practice settings, it is an integrated role.

The Diploma of Higher Education in Nursing Studies course is a three year programme, and each academic year consists of forty five weeks. Fifty percent of a student's time is spent in the College and fifty per cent in gaining practice experience in practice placement settings. The ENB (1993, section 2) recommends that nurse teachers should spend at least one day per week, teaching in placement settings, and although the College supports this philosophy, no official time for this activity is timetabled into the teachers' working week.

It is therefore understandable that, there was confusion about the precise role of the nurse teacher in practice settings. On discussing this outline description with the teaching staff it became apparent that it was, in fact, an outdated statement in relation to the College's definition of the role of the Clinical Teacher, a post which no longer exists. The clinical teacher, working in the practice setting, was given the responsibility of feeding back to the nurse tutors information about changes taking place in practice. In theory, the nurse tutors could then relate their theoretical teaching to practice.

At the time of the inception of the role of the "link teacher", the role itself had evidently never been adequately conceptualised or defined. As a result there were no indicators as to the College's expectation of the teacher in relation to student support within practice settings, and no guidance for the performance of that role has ever been established. Therefore each teacher performs the role according to their own interpretation, some of them supporting student nurses, some of them supporting practitioners in their teaching role and some performing a combination

of both.

A central concern of nurse education in recent years has been the perception that there is a theory / practice gap. Authors such as Owen (1993), Northcott (1988) and UKCC (1986, p9), have attributed this to the role undertaken by nurse teachers in practice settings. A new approach to nurse training, "A new preparation for practice - Project 2000" (1986) was intended, by the Statutory Training Bodies, to close the theory / practice gap since it places greater emphasis on the importance of demonstrating the integration of theory and practice within the curriculum. The importance of linking theory to practice in a range of settings was also emphasised.

However, a recent national research study conducted by Jowett et al (1992, p61) into the introduction of the new format of training, highlighted that the anticipated reduction of the theory / practice gap has not, in fact, been achieved. The report indicated that, on a national basis, nearly half of the student nurse respondents interviewed felt that a mismatch did exist between theory and practice. As this College of Health participated in this research, an assumption could be made that a theory / practice gap does exist in delivery of its curriculum. Therefore an exploratory exercise would assist in identifying the role determinants and characteristics of nurse teachers which either contribute to, or detract from, this perceived gap. It would also assist in establishing a role specification for nurse teachers in practice settings.

Specific research questions to be addressed.

In order to establish what would be an appropriate supervisory role for the nurse teacher these specific research questions would first have to be addressed:

(i) did the students and teachers at the College and clinical practitioners feel that there was a gap between theory and practice in the training programme ?

(ii) if they felt there was a theory / practice gap, did they attribute this to the quality of the supervision provided by the nurse teacher ?

(iii) to what extent did the different role definers agree about the supervisory role that the nurse teacher should undertake ?

(iv) could agreement be reached between nurse teachers and practitioners on a draft role specification for nurse teachers in practice settings?

If agreement could be reached on a draft role specification then it was my intention to see if this could be trialled in the practice settings and revised in the light of this experience. Following this, the responsibility for this aspect of the nurse teacher's role could be written into a formal job description and policy documentation.

Rationale for study.

As the educational manager with responsibility for, not only the delivery of the curriculum and the implementation of policies and procedures but also for, the development and deployment of nurse teachers, the findings of this piece of research will inform me as to the best utilisation of nurse teachers in practice settings.

The introduction of changes to the management of the National Health Service has brought with it, not only the introduction of greater financial controls but also a change in the method of

funding of nurse training (Working Paper 10 - 1989a). Mason and Jinks (1994) have identified that the Griffiths Report (DHSS, 1983) and the White Paper (Department of Health, 1989b) have promoted a market approach to the provision of health care, in which nurse education and nursing service are considered as separate issues. It was even stated (Department of Health, 1989 b) that contractual arrangements between the two groups will become necessary if the education of student nurses in the clinical areas is not to be compromised. The combination of these changes resulted in the concept of "purchaser" and "provider", with the purchaser looking for quality products and "value for money". The contractual agreements between the purchaser (N.H.S. Trusts) and provider (College of Nursing) has resulted in the need for greater specification from purchasers of what they expect from their financial investment into an educational programme. Failure to meet the contractual arrangements could result in the loss of training contracts. Therefore, as a manager, I consider it to be imperative that there are quality control mechanisms in place to ensure that the education and training provided by the College meet the requirements of the Trusts and, more importantly, that the education and training produces competent practitioners.

A study of the role of the nurse teacher in practice settings, and the elaboration of that role would be one way of enhancing quality measures within the delivery of the curriculum. Many authors have written about the role of the link teacher, but this study widens the concept by analysing and defining a locally acceptable role, and then through an action research approach evaluating that role in action. In this sense, this piece of research breaks new ground.

The introduction of the new format of training - Project 2000 (1986), recognised the need for integration of education and practice and for nurse teachers to be competent in nursing theory and practice and be able to facilitate learning in the practice setting and in the School or College

of Nursing. I felt that it was essential, therefore, that an exploratory study be undertaken to identify how this could be achieved and to clarify the role of the link teacher. If a role specification could be agreed this would not only enhance the teachers own "job satisfaction", but the clarification of the role and standards, against which the performance of the role can be judged, could help reduce any perceived theory/ practice gap.

The majority of the recorded research studies into the role of the nurse teacher in practice settings appear to have been undertaken in the field of Adult (General) Nursing in Acute Hospital settings. Within Project 2000 training there are four branches of nursing, each with its own diverse range of clinical practice requirements. These four branches being: (i) Adult - equating to Registered General Nurse; (ii) Child - equating to Registered Sick Children's Nurse; (iii) Learning Disability - equating to Registered Nurse for the Mentally Handicapped and (iv) Mental Health - equating to Registered Mental Nurse, and each requiring placements in hospitals as well as in the community.

This piece of research examined the enactment of the role of the link teacher in a whole range of practice placements in order to determine whether it was possible to derive a consensus view on a "defined" role which was operational in all areas of practice. In this context, this aspect of the research adds to the literature on the role of nurse teachers in practice settings.

<u>An additional factor outlining the necessity to define a role for nurse teachers in practice settings.</u>

The Regional Health Authority has recently decided with which centre of Higher Education the College is to link and the identified University's tender document (UWE 1995, p55) stated:

> "Our preliminary view is that clinical teaching, supervision and assessment should be undertaken by staff with appropriate experience and qualifications in the clinical setting. College based staff would continue to visit placements to ensure effective audit, liaison

> and co-ordination. This would not require all students to be visited on each placement by a college teacher, although they would be available at the request of student or clinical teacher".

Nurse teachers currently visit all students on each of their practice placements and the possibility that the number of these visits might be reduced was a cause of concern to them. The teachers stated that the development of practice links was based on "good will" built up between themselves and the practitioners. This had been achieved through the support given to the practitioners, and the teachers therefore feared that if the number of visits were to be reduced, this "good will" would be lost. As the University has stated that it "would wish to explore variants of the (link teacher) model" (UWE 1995, p55) the findings of this study should then inform the debate and assist the Faculty in their decision making process.

Style of writing used in the dissertation.

I have used the first - person pronoun in the writing of this dissertation because I believe that it is important for readers to be aware of my role in the shaping of a defined role for nurse teachers in practice settings. Webb (1992) pointed out that the third person pronoun is used in academic writing to convey "an impression that the ideas being discussed have a neutral, value free, impartial basis (which) is rarely if ever the case". But Gouldner (1962) argued that value-free sociology is a myth designed to allow sociologists to be morally indifferent and thus to escape from the implications of their work. DeGroot (1988) further questioned the notion of objectivity and proposes that the subject, research questions, methods of data collection and analysis result from the researcher's own personal experience, values and perceptions. Porter (1993) argued that the interpretations, values and interests of the researcher are, in fact, central to the research process, particularly as nurse researchers are part of the social situations they study. Reason & Rowan (1981, p46) do not explicitly advocate the use of the first person, but

do support that making it clear "where one is coming from" contributes to making research "objectively subjective", which is the basis of "new paradigm research". My research has been a two-way process of interaction and sharing between myself and teachers and practitioners. Through the use of the first-person pronoun I have attempted to explore my perceptions of how I have influenced the research process when writing up the dissertation.

CONCLUSION

This chapter has outlined the main purpose of the study which is to develop an agreed specification for the role of the nurse teacher in practice settings. The specific research questions through which this problem would be addressed were enumerated.

The following chapter outlines the contextual issues which impinge upon, and create demands upon nurse teachers' time and commitments and, therefore, which have implications for the performance of their role in practice settings.

Chapter three outlines a review of the literature on theory and the role of the nurse teacher. Broad issues which required exploration were identified and incorporated into the research study.

Chapter four describes the research methodology which was predominantly action research and it also describes the action taken in each of the four stages of the research.

Chapter five outlines the method by which a draft role specification, for the performance of a nurse teacher in practice settings, was agreed by three groups of role definers.

Chapter six outlines the process by which negotiations took place to identify volunteers to trial

the new role in a range of placement settings.

Chapter seven describes the process through which the role of an educational facilitator was evaluated in practice, through the use of reflective accounts, written by volunteer teachers and practitioners.

Chapter eight are my reflections on the process, by which the role was defined and agreed, and the product arising from the research. It also outlines the recommendations which were made to the relevant organisations/ committees.

CHAPTER TWO.

CONTEXTUAL ISSUES

The study was undertaken in the context of the introduction of Government and Statutory Nursing policies which impinge upon, and create demands upon nurse teachers' time and commitments. An outline of these policies and the effect of their implementation over the period when the research was undertaken is outlined in Appendix 1.

Many things have changed within the National Health Service since the 1980's, and no doubt change is likely to continue. The role of the nurse teacher revealed in this research project, and the effects of the implementation of Government and Statutory Nursing policies upon the performance of that role is, therefore, a snap shot in time within one College of Health.

Recent history of nurse teacher education nationally.

From 1962 until 1987 there were two grades of nurse teacher training courses. One was for the preparation of a clinical teacher whose training specifically prepared them to teach practical nursing. These clinical teachers performed their role primarily in ward based settings and held a lower position in the teaching hierarchy than nurse tutors. Nurse tutors' training on the other hand prepared them specifically to teach in classroom settings. The clinical teacher, working in the practice setting, was given the responsibility of feeding back to the nurse tutors information about changes taking place in practice. In theory, the nurse tutors could then relate their theoretical teaching to practice.

The Annual Report of the English National Board for Nursing, April 1985 - March 1986 (ENB 1986, p8), proposed a strategy for change in the professional education and training of nurses,

midwives and health visitors (Project 2000). The ENB (1986, p12) stated, that it believed, a further integration of teaching and practice was essential in the future preparation of nurses and recommended that:

> In the proposed new course (Project 2000), it will be vital for teachers to be involved in the whole curriculum - enabling the learning of theory and application of that theory in practice. The Board proposes that in future there should be, within nursing, a single category of teacher.

Explicit within this statement is the concept of the combined role of clinical teacher and nurse tutor (the new generic title being nurse teacher). But the ENB did not clarify the expected performance criteria for the new role. Midwifery teachers had for some time been performing the combined role and for this there was a compensation in the allowance of the ratio of student to teacher of 10:1. The ENB, although recommending a change in function for nurse teachers, did not make any adjustment to their agreed ratio of 15:1. This may have been an oversight or possibly because of cost implications arising from there being far more nurse teachers in post than midwifery teachers.

The ENB made available re-training courses to all clinical teachers who were employed in Colleges of Nursing to prepare them for their new classroom teaching role. This was an aspect of teaching that had not been included in their clinical teachers course. Yet, at the same time, retraining courses for nurse tutors to prepare them for their proposed practice placement role were not made available. This may have been because a requirement to become a nurse teacher is for a Registered Nurse to have "clinical expertise" and, therefore, the ENB may have assumed that, although the role of the nurse tutor was firmly in the classroom, they would have maintained this expertise.

In 1988 the ENB issued its criterion for the selection of nurses to become nurse teachers (the

new embracing terminology for the combined role), and this was that they should be an "expert in her/his profession". Although recommending a single category of teacher, the ENB did not recommend a change to the initial training they should receive. The "clinical experts" would still undertake a theoretical based teaching course which would prepare them to teach only in the classroom setting and not at the bedside. However, there was no recognition of the fact that once entrenched within the classroom, it is very easy for the teacher to become "clinically outdated" in the skills which were their main qualification for entry into nurse education.

The clinical role of the nurse teacher is, perhaps, assumed by many people to be in clinical teaching, however, one of the major anxieties faced by nurse teachers who have been classroom based is the loss of their clinical skills and, therefore, they may not feel adequately equipped to work in these areas. This could be a contributing factor to the perceived theory /practice gap, as identified by Owen (1993), Northcott (1988) and UKCC (1986, p12) in nurse education.

(ii) The impact of implementing government / statutory policies at a local level.

The implementation of Government reforms and Statutory policies, specifically Project 2000 had major consequences for the provision of nurse education in the N.H.S. Trusts served by the College. Some of the main implications of these policies are discussed in the following paragraphs.

(a) Formation of College of Health.

The formation of a College of Health consisting of Midwifery, Nursing, Physiotherapy and Radiography education which commenced in January 1987 with a feasibility study was finally completed in August 1993 when all disciplines were on site. The College's Department of Nurse Education was formed by the amalgamation of thirteen Schools of Nursing which were

based in local hospitals. The formation of the College of Health has changed the relationship between nurse teachers and staff of the local N.H.S. Trusts. Nurse teachers were formally employees of the hospital and, therefore, interaction between the staff allowed for practitioners and teachers to work together and update each other on relevant issues. As the Schools of Nursing were on the "door step", practitioners were able to visit their respective School on a regular basis and, more importantly nurse teachers were able to visit the placement areas on a frequent, basis even if it was for a short period of time, in between classroom sessions. The formation of the College resulted in the closure of the hospital schools and the re-siting of all teaching staff onto a single site which was quite independent of any of the hospitals. The teachers are now employees of the College and not of hospitals, resulting in a change in the working relationship between the two parties. Mutual updating is becoming more difficult to achieve because of the purchaser/provider relationship and the cost implications of such activity. A further consequence of bringing the smaller schools of nursing into one College of Nursing is that the number of people in a role relationship with nurse teachers is greatly increased.

(b) Introduction of Project 2000 Course.

The document "A new preparation for practice" - Project 2000 (1986), outlined the necessity for Colleges of Nursing to link with an institution of Higher Education so that the academic outcome of a Pre - Registration Nursing course is accredited, at least at the level of Diploma of Higher Education, as well as leading to a professional qualification in nursing. There was also a requirement for an increase to the theoretical input to the whole course, from approximately one sixth of a conventional nurse training programme to one half of a Project 2000 programme. The requirement for the increase to the theoretical input has ultimately decreased the amount of time available for nurse teachers to undertake other educational activities. There was also a requirement for a change in the emphasis of the curriculum and so, not only are the teachers

expected to teach to a greater depth but, in addition, to teach a wider curriculum. Consequently many of the teachers had to learn some of these subjects in advance of teaching them to the students.

The practice placement requirements for the delivery of Project 2000 also present challenges, since students are required to gain experience in a whole range of practice settings including hospital, community, private organisations, local authorities and local Special Education Schools.

As a result a total of five hundred and forty three practice placement areas are currently used in the student nurse training circuit. The college links with five local NHS Trusts, spread over a wide geographical area, each offering a different range of clinical experiences for students. Many of the teachers already link with more than one specialist nursing area, and in some instances to areas in which they have had no previous nursing experience. Because of the diversity of service delivery in Community, Mental Health and Learning Disability specialities, the link teachers to these areas may be responsible for as many as thirty placement areas and therefore can spend a considerable amount of time travelling from site to site. Whereas, the service delivery of Adult and Child nursing is mainly institutional based in hospital settings, as a result these placements have students at differing stages of their training allocated to them at the same time. Therefore these link teachers, although linking with only four or five placement areas, have an increased number of students requiring varying levels of support.

The challenge is, therefore, to establish and maintain meaningful practice links so as to assist student nurses to practice. This will be difficult to achieve when the very much reduced work force, working from a centre of Higher Education, will not between them possess all of the required clinical expertise to match the practice areas used in the training circuit.

(c) Graduate status of nurse teachers.

The ENB (1990a, p17) recommended that, by 1995, all teachers of Nurses should be graduates. This has also become part of the Government Health Department and the Nursing Division policy (DoH 1989c). There are pressures on many nurse teachers to obtain relevant higher degrees and, in order to achieve this objective, the college releases the equivalent of seven full time teaching staff on any one day. This effectively reduces the available workforce to perform all of the duties that are required to deliver the programmes. Because of the emphasis on teachers gaining graduate status and the increased theoretical input into the Project 2000 training, some nurse teachers are reporting that they are finding it more difficult to visit the practice areas. They are, therefore, unable to keep up to date with current clinical practice, and so it can be questionable as to whether the nurse teachers can ensure that what is taught in theory relates to what is carried out in practice and vice versa.

(d) Effect of the contract culture.

The contract culture of the purchaser/ provider relationship is already affecting the world of nurse education in that the number of student nurses contracted by the Regional Health Authority to be educated and trained for the local NHS Trusts has been reduced. As a result this College will have to reduce the number of nurse teachers it employs by almost 40% over the next three years. The remaining teachers will have the added responsibility of ensuring that practice links are maintained, thus requiring a greater range of placement areas to be covered by each nurse teacher. But at the same time, the United Kingdom Central Council for Nurses, Midwives and Health Visitors (1987, p28) recommended that nurse teachers must possess an up to date overview and understanding of the care settings to which students are allocated. Under such circumstances this will be difficult for teachers to achieve.

(e) Effect of skill mix reviews in the N.H.S. Trusts.

The complexity of the placement issue is an added dimension. A review of the tasks which can be performed by the different grades of nurses, undertaken in the local N.H.S. Trusts, and the number of staff needed in each grade have resulted in a reduction in the number of Registered Nurses, and an increase in the number of Health Care Assistants employed in each area. As a consequence Registered Nurses "have faced a vast increase in their workloads with a smaller number of qualified staff" (RCN 1992, p5). Also the number of student nurses that can be supported in each area is reduced. Therefore students are allocated thinly across practice placements. This, it may be argued, is educationally viable for the students but not all of our students are in agreement with this as they miss "peer support" from their colleagues. Also it creates "head aches" for the teachers who have to link with all of these areas.

It is an ENB Statutory requirement (1993, section 2) that, within clinical areas selected for the training of student nurses, the "teaching and supervision of students must be the responsibility of an appropriately qualified and experienced first level nurse", and that "staff should demonstrate enthusiasm to share their expertise". It is also a requirement that Registered nurses should attend preparatory courses to prepare them for their teaching role. Indeed, in my own College, preparatory teaching courses for practitioners are organised and, as an example, in 1994 one hundred and twenty five Registered nurses undertook the fifteen day ENB 998 course (Teaching and Assessing in the Clinical Setting -1985). Two hundred and seventy five additional staff undertook a two day Mentor/ Assessor Course and there is ongoing Key Worker Training in the Mental Health field. But, despite the preparatory teaching courses to prepare practitioners for their teaching role, student evaluations indicate that in some of the placement areas they are not receiving the support they expect from the practitioners. Registered Nurses have identified (Hydes 1995) that they may not be able to cope with the conflicting demands of caring for

patients and teaching and assessing both student nurses and health care assistants.

(f) Integration into Higher Education.

The shift in Pre -Registration nurse education to diploma level studies, and the gradual move towards integration with Higher Education, raises questions about the support and supervision of student nurses in practice settings. Teachers are voicing their concerns, that following integration, there may be a further clash of values between professional and academic loyalties. There may be tension resulting from the competing pressures of the necessity for nurse teachers to update their clinical skills (UKCC 1986, p58) and the emphasis in Higher Education on "scholarly activity".

Teachers' credibility.

What are the implications of these Government and Statutory requirements for the role of nurse teachers ? Slevin (1992), the Chief Executive of the National Board for Nursing for Northern Ireland, has highlighted the importance of nurse teachers demonstrating competence in four areas, that of teaching, knowledge, clinical and academic credibility. Central to the debate in relation to the role of the nurse teacher is the relative importance of their educational and clinical credibility. Chambers' dictionary defines "credibility" as "worthy of belief or of confidence", and therefore having the ability of acting as a role model to students. Much time and effort has been invested in my own College of Health into allowing nurse teachers to gain graduate status and to increase their knowledge, but without a similar amount of investment into ensuring they are equally credible in nursing practice. The increasing interest in nurse teachers obtaining degrees may hinder rather help link theory to practice.

CONCLUSION

In this chapter I have described the local implications of implementing Government and Statutory policies within this College of Health, doubtless it is not alone in experiencing such effects. In the following chapter, I put my research into perspective within the national picture and explored published research on the role of the nurse teacher in practice settings, in order to establish whether satisfactory solutions have been established elsewhere. Also to set the framework for the research the questions to be posed to the potential role definers were identified. The literature review was undertaken in the context of role theory.

CHAPTER THREE.

REVIEW OF THE LITERATURE ON ROLE THEORY AND THE ROLE OF THE NURSE TEACHER

What is the role of the nurse teacher? How can the role of the nurse teacher be defined? The literature on role theory provides a theoretical framework in which these questions can be obtained. Handy (1985, p57) suggested that role theory, the study of an individual and his roles, provides a framework for understanding why the world is not as easy a place to manage as it should be. It provides one way of linking theories about individuals to theories about organisations.

But how is role conceptualised? Rodgers Ward (1986) explained that the language of the theoretical perspectives of "role theory" consists of their designating terms with meanings, although the precise meanings of many of these labels have not been identified by the social scientists. However, Rodgers Ward (1986) suggested that the most important criterion for selecting the appropriate definition of a concept is its probable utility in developing a formal theory.

My review of the ways in which "role" is defined has revealed a striking diversity of definitions eg. Linton (1936, p105) "sum total of the culture patterns associated with a particular status"; Bennett & Tumin (1948, p96) defined role as "what society expects of an individual occupying a given status"; Newcomb (1951, p280) "the ways of behaving which are expected of any individual who occupies a certain position constitutes the role associated with that position"; Gross et al (1966, p18) "a set of expectations, or in terms of our definition, it is a set of evaluative standards applied to an incumbent of a position".

Gross et al (1966) discussed definitions used by other social scientists in order to set the content for, and to define the terminology used throughout a study which they conducted in 1966 on the role of the headmaster. They reexamined and conceptualised the definitions of "role" in the social science literature and the claims for the definitions of the word "role" contained within them. Gross et al considered definitions used by other authors and accounted for some of the differences they identified by concentrating their examination on how other social scientists treated the phenonemon of "role consensus". They explained that involved in many, but not all, formulations of the role concept in the social science literature is the assumption that consensus exists on the expectations applied to the incumbents of particular social positions. Gross et al (1966, p28) pointed out that many social scientists inferred consensus was present by writing "ascribed by society" and ignored the problem of who the role definers of the expected behaviours were. They also explained that, quite often there is an untested assumption that the members of a society hold the same expectations for the incumbents of the same position, therefore, the population of role definers may be a significant factor in the degree of consensus an investigator finds. Gross et al (1966, p28) highlighted that it is important for the researcher to be explicit about the identity of the role definers and to define what constitutes "consensus".

<u>The issue of consensus amongst the role definers.</u>

As two of the specific research questions which I have identified on page 5 examine the extent of agreement between role definers, the issue of "consensus" raised by Gross et al had important implications for this piece of research. Therefore, as many of the other social scientists eg. Linton 1936, Bennett & Tumin 1948 and Newcomb 1951, had not been precise about this aspect of role theory I selected, and primarily used as the basis for analysing the role of the nurse teacher in practice settings, definitions of role theory as described by Gross et al (1966).

Through out the document I have therefore, been explicit as to who were the role definers and what constituted consensus amongst them. External validation of a role is based upon ascertaining whether the behaviour is judged to constitute a role by others whose judgements are felt to have some claim to correctness or legitimacy. The role definers within the world of Nurse Education, who could claim some legitimacy in judging the constituent parts of the role of the nurse teacher in practice settings, include practitioners working in the practice settings, managers of clinical services, student nurses and nurse teachers themselves.

Gross et al (1966, p213) addressed the issue of consensus when they explained that "the degree of consensus on the expectations from each alternative can be inferred from the percentage who feel any action would be approved". For the purpose of this piece of research, I inferred that consensus existed when there was at least 75% agreement on any of the responses to the identified questions in the questionnaires / semi-structured interview schedules.

<u>The commonality of role definitions identified by Gross et al.</u>

Gross et al (1966, p18) also highlighted three common elements, identified by other social scientists, which theoretical formualtions concerned with role analysis must include. These three elements are - social locations, behaviour, and expectations - which are common to most of the definitions of role which they reviewed. These three elements gave me direction for the design of the research instruments ie. questionnaires and semi - structured interview schedules, which allowed me to investigate the stated role definers expectations for the behaviour of nurse teachers in practice settings. As a result, arising from the analysis of the material derived from the reserach intruments, a consensus view on a defined role for nurse teachers was identified.

Gross et al (1966, p11) emphasised that many authors have used the concept of role to embrace

the normative element of social behaviour, in that people do not behave in a random manner; their behaviour is influenced to some extent by their own expectations and those of others in the group or society in which they are participants. Doheney et al (1982, p77), when writing specifically about nursing, pointed out that quite frequently role is defined in terms of function or duties, but this can put limits or constraints on (the teachers of) nursing since it dictates specifics rather than viewing the role of (the teacher of) nursing from a broader aspect. They further pointed out that even though consumers of the teaching process have definite expectations of teachers, they remain unclear as to the role of the nurse teacher.

A review of the methodologies used by other researchers to identify a role for nurse teachers in practice settings

A review of the literature has revealed that there are few studies on the actual activities which nurse teachers undertake in the practice settings. Some authors (Bond 1985, Northcott 1988, Osborne 1991, Fawcett & McQueen 1994) have written about the role of nurse teachers through the expression of their own personal convictions of what they should be doing in these circumstances. The majority of the studies on different aspects of the role of nurse teachers have been conducted through the use of empirical studies and an exploration of some of these studies is outlined in the following paragraphs.

Bendall (1975) reached her decision that teachers of nursing should teach nursing skills in the real situation, rather than simply imparting knowledge in a classroom situation, from her research into how nurses in training described nursing care. Her small scale research was conducted in three schools of nursing through non participant observation of trainee nursing practice in the wards and then by obtaining verbal descriptions from the same subjects of the same practice. An attempt was made to ascertain students' perceptions of their nurse teacher

on an ideal - non ideal continuum.

A larger survey was conducted by House & Sims (1976) through the use of a questionnaire posted to 2923 Registered nurse teachers. The response rate from this survey was very small, with only 956 (32%) teachers returning the questionnaire. Those who did return it provided additional comments and revealed a common dissatisfaction with the role because they regarded it as ill-defined.

Stephenson's (1984) study described her research which focused on selected items from an earlier exploratory study of nurse teacher - student nurse relationships. Her research was conducted from a sociological perspective using role theory as the organising theoretical framework. The sample group used in the study was quite small, consisting of 22 student nurses in their first, second and third years of training and 23 nurse teachers. Stephenson gathered her data through the use of semi-structured interview schedules. A qualitative methodology was used to analyse the data involving the use of a modified grounded - theory approach, which included categorising the data and using the categories to generate further data. The research findings highlighted that if teachers are going to meet students' expectations they need to be available in the clinical areas to conduct clinical teaching. Stephenson acknowledged that role behaviour was not observed in her study but that there was a need for analysis of teacher - student interactions to illuminate knowledge about relationships.

Jones' (1985) small scale study into nurse teachers conceptualisation of their ward teaching role focused on the identification of factors which mitigate against their teaching in the clinical areas. The first stage of the project involved the use of the repertory grid technique and from the results, a semantic differential questionnaire was built up and used for an attitude survey of a

second sample of nurse teachers. The results showed that the main factors leading to a lack of clinical teaching by nurse teachers included lack of control and a sense of conflict.

Rating scales were used by Morgan & Knox (1987) with 201 student nurses in a Canadian study and by Flager et al (1988) with 155 student nurses in an American study to identify beneficial clinical teaching behaviours of nurse teachers. Morgan & Knox's study identified that the respondents perceived the "best" clinical teachers as good role models as the ones who enjoyed nursing and teaching. Flagler et al's study revealed that the behaviour of a nurse teacher which helped with the students' self confidence as a nurse was when they responded to questions and gave positive feedback. In both studies it was emphasised that in order to acheive the students' expectations it was necessary for the nurse teacher to be "out there in practice settings".

Clifford has, on several occasions, described the results of selected findings from a small scale exploratory study of the role of the nurse teacher which she conducted through the use of a questionnaire circulated to 66 teaching staff in one College of Nursing. Clifford's (1992a) article outlined that both quanitative and qualitative data was collected from the questionnaires. The quantitaive material included a range of biographical detail; an outline of career patterns; professional qualifications and specific preparation undertaken for a teaching role. The qualitative material which she gathered was categorised into themes which included the identification of factors that influenced decisions to work in nurse education; educators' views on preparation for the teaching role and areas of satisfaction and dissatisfaction in their work.

Clifford, whilst acknowledging the limitations of the small scale sample size and the narrow focus of the findings, identified that the report gave a basis from which to devlop further study into the role of the nurse teacher.

Clifford (1993b) reported on the same small scale exploratory study, but this time she discussed three different areas. These were (i) the examination of the number of clinical areas teachers linked with and the different models of clinical contact that she identified (ii) the frequency and timing of teachers' visits to the clinical and (iii) the nature of the clinical role with emphasis on liaison and teachers' perception of support to students and the clinical staff. Clifford concluded by acknowledging that all three areas require further analysis if the role of the nurse teacher is to be clarified and made more effective in the future.

The emerging role of the nurse teacher in Project 2000 programmes was initially explored by Crotty & Butterworth (1992) through the use of a literature review as the basis for a research study which they subsequently conducted. Their research study critically analysed the key components of the role of the nurse teacher, the methodology and findings of which were described by Crotty (1993a). A three-round Delphi study was conducted, with the panel of experts consisting of 201 nurse teachers drawn from 25 of the 28 colleges in England who had implemented Project 2000 between September 1989 and April 1991. The findings of the study highlighted the complex and multi-faceted role of the nurse teacher and the enormity of the task of the nurse educator. Implied within the reform of nurse education through Project 2000 is a change in the role of the nurse teacher. The major changes which Crotty reported are those related to teaching and learning activities. There is a new emphasis on the level and depth of teaching, the specialist nature of the teaching and on teaching to a variety of courses at diploma and degree level.

Crotty (1993b) explored more fully the findings from the Delphi survey through in-depth interviews with a sample of respondents from 6 of the 25 colleges. The findings identified a very strong commitment of the respondents to a clinical liaison role, and they did not perceive

their role to be one of teaching students "hands on care"; they felt this was the role of the qualified staff in the clinical areas.

The exploration of these studies has revealed the variety of methods which have been used to research into the role of the nurse teacher in practice settings and the diversity of views which have arisen from them. None of the researchers used an action research approach to confirming a role that they identified in practice and therefore, in this context my study is breaking new ground. In my study nurse teachers and practitioners were involved in both identifying and trialling a role for nurse teachers in practice settings and therefore, have ownership of that role. It is interesting to note that, in several of the studies which I have reviewed a suggested role for nurse teachers in practice settings emerged (Clifford 1993b and Crotty 1993b), however no follow up reports of the role being trialled in practice have been identified.

As this exploratory study of the methodologies used in previous studies did not provide me with any answers, I decided to explore the different views of the role of nurse teachers in practice settings from another perspective.

<u>What are the differing expectations for the role of the nurse teacher in practice ?</u>

Role has reference not to the actual behaviour of an occupant of a position but to behavioural standards. Human behaviour is thus influenced by some degree by the expectations individuals hold for themselves or which others hold for them. This was specifically noted in relation to nursing by Doheney et al (1982, p12) when they highlighted that, due to the social nature of nursing, people have different expectations of the role of the nurse. Stephenson (1984) has also noted that, the social world of the School of Nursing may be deemed as a social system within which peoples' behaviour towards the occupant of a particular role is based on the assumption

that a person in that role generally confirms to certain expectations and obligations.

Other authors (Inglesby 1986, Crotty 1993a), on the role of nurse teachers have identified the complex situation in which nurse teachers operate. Student nurses may, for example, expect one set of behaviours from nurse teachers, while practitioners and line managers of nurse teachers may expect rather different sets of behaviours from them. And finally nurse teachers themselves will have their own set of role expectations.

<u>The expectation that the nurse teacher should be at the bedside.</u>

Many authors have argued that the nurse teacher can best demonstrate their role in practice settings by acting as a role model to student nurses by delivering "hands on care".

Authors such as Bendall (1975, p66), Weatherston (1981), Lee (1993) have emphasised the dissonance between educational providers, ie the Schools of Nursing who teach theoretical concepts of care in the classroom setting, and the care providers whose main aim is to provide care to the patients and not to care for the educational needs of student nurses, thus bringing about a perceived theory / practice gap in nurse education. These authors have advocated that the role of the nurse teacher is at the bedside delivering hands on care, acting as a role model to student nurses by demonstrating clinical credibility. This, they suggest, should bring about the desired integration of theory with practice.

The issue of the clinical credibility of the nurse teacher must be considered against the backdrop of other role demands that, arguably, have necessitated a re - interpretation of what is meant by "credibility". Interpretations of this concept appear to run along a continuum from the belief that nurse teachers should also hold a significant clinical post (Bond 1985) to the belief that it is

entirely inappropriate that nurse teachers, seen as essentially responsible for the theoretical underpinning of practice, should also have clinical responsibility (Infante 1986). Between the two extremes are interpretations which may go some way to resolving what appear to be diametrically opposed views. These interpretations look at the nurse teachers' role in the terms of liaison and the complementarity between the teacher and the clinical preceptor, whereby clinical involvement and responsibility can be mutually negotiated and determined.

Arguments for the bedside role.

Peters (1964, p23) warned that professional judgement cannot be learned from books or formal lectures alone, and further warned that nurse teachers should take particular note of that comment, for they will be the appropriate role models for nursing students only if they are also nursing practitioners, sharing real life nursing care activities with their students. This view is also shared by Inglesby (1986) and Clifford (1993). In order to achieve such aspirations the Judge Report (RCN 1985) recommended that future nurse teachers should carry clinical responsibilities.

The importance of nurse teachers being involved in clinical activities as a means of being a "good role model" and providing feedback to students has also been identified in studies conducted by Windsor (1987), Morgan and Knox (1987) and Flagler et al (1988). Northcott (1988) argued that the integration of clinical activities into the teachers' role will remind them of their own learning potential, he also stressed the importance of the relationship between theory and the practice in which students finds her/himself engaged in, and for the nurse teacher to be there to make sure that the link is appreciated by the student. Jarvis (1987), McNaughtery (1992) emphasised the argument in a similar vein, in that clinical practice should receive adequate attention from teaching staff, which includes increased teacher contact at the bedside.

How has this challenge been tackled by the Statutory Bodies ?

Originally, teachers of nursing were practice based and, according to Bendall (1977, p174), in the first quarter of this century the General Nursing Council (for Nursing) made the decision to remove official nurse teachers from their practising role in the placement areas, and provided them with a training programme. The teachers, according to Bendall, then "inevitably" became theoreticians, hence the rise of the theory / practice gap. Kirkwood (1979) reported that the decision to remove the official teacher from the ward was taken in order to alleviate the role conflict which was inherent to dealing with the two roles of "nurse" and of "teacher".

But, for teachers, acting in the role of theoretician there were also inherent problems. This was identified by Bendall (1977, p173) when writing "the person of the nurse teacher is not clear cut, identifying the problem in that it depends on what is meant by "teaching"; on the surface those who officially teach (the nurse tutor) are clearly theoreticians - who do not practice: but they are only in contact with the learners for some twenty per cent of their course time. For the other eighty per cent of the time, the learner is in contact with trained, clinical nursing staff, who may or may not teach".

Out of such circumstances arose the role of the clinical teacher, a role which was identified as a way of providing more consistent teaching in the clinical area, as ward sisters were finding it increasingly difficult to teach students. The clinical teachers' role was to guide students in the application of theoretical knowledge to the practical skills and realities of nursing and "to increase the amount of bedside teaching and supervision of students" (GNC 1963, p15), and therefore to bridge the theory / practice gap. But as Robertson (1987, p17) identified "just what bedside teaching and supervision might entail, was a matter of some debate". An exploratory study by Robertson (1984) showed that there were a number of differences in the expectations

which different groups of people had of clinical teachers and in the ways in which clinical teachers actually worked. As a result of the problems encountered by clinical teachers in meeting the conflicting demands of school and clinical practice, there were recommendations that the role be discontinued in favour of a system with one grade of nurse teacher (RCN 1983, p45; ENB 1986, p70). Although these recommendations were implemented from 1987 onwards, they were not accompanied by a role specification for the performance of this new role being put forward from the Statutory Bodies.

The apparent ineffectiveness of the bedside role.

Increasingly the evidence suggests that teaching by demonstrating giving direct care to patients is, perhaps, an unrealistic expectation for nurse teachers.

Wyatt's study carried out in 1978 identified that "students see the teachers as remote, assessment - orientated and unable to teach the skills of adapting to the constantly changing demand of clinical practice". And in relation to their remoteness, Quinn (1988, p205) recorded that she regarded it as a major anomaly within the system that nurse teachers no longer practice what they preach. Jones (1985) identified that, even when time was available, nurse teachers were more at ease when taking on supportive, advisory roles rather than participating in direct clinical activity. Her study highlighted that nurse teachers felt neither prepared nor competent to teach in the practice settings.

But why is the bedside role of the nurse teacher not effective ? One reason identified by Kershaw (1990), did not lay the blame with nurse teachers themselves but argued that due to a lack of funding they were not allowed sufficient time to pursue this role.

Another reason, put forward by Burnard (1992), is in relation to documents such as the Strategy for Nursing (1989), which he suggested are often written by those who do not have direct responsibility for translating them into action. Burnard suggested the difference between the expected outcomes arising from policy making documents and the reality of implementing these policies in practice as a potential cause for the theory/ practice gap. He further suggested that there is plenty of evidence to demonstrate a "theory / practice gap" but precious little on exactly how nurse teachers are to fulfil the multi - faceted role that has been outlined for them. Burnard also highlighted that it is a stressful time for nurse teachers at present since they are trying to adapt to the role changes required as a result of the important changes in the training and education of nurses. He questioned whether, amidst all of these changes nurse teachers should also be expected to be excellent practitioners. A major reason which appears to have been a constant factor appears in references to role conflict caused by the expectation that "nurse teachers" will also be "nurses".

Role conflict described, by Biddle & Thomas (1966, p8), as "contradictory expectations held for the incumbent of a single position" was identified as being experienced by nurse teachers, in the performance of a clinical practice role, as early as the first part of the century. This was noted when the GNC (1923) removed practice based teachers from the placement settings for this very reason. Research by House & Sims (1976) identified role conflict for clinical teachers, in that they felt their role was ill - defined and devalued and related to feeling a guest on the ward and having little control over, either the patient or, the educational processes there.

Many authors on the role of the nurse teacher have identified a causation factor of role conflict as arising from the very title of "nurse teacher". McCaughtery (1991) commenting that an "overt sign of the inherent tensions and difficulties of the role; the title itself signifies a dual

role, the necessity to be both nurse and teacher". McCaughtery (1991) asks whether this is correct, particularly in a society that recognises that for many occupations the role of practitioner and teacher are sufficiently demanding in themselves, and further asked if there something special about nursing that allows them to be combined?

Hingley & Cooper (1986, p59) in their study of stress in senior nurse managers identified that the lack of role clarity was likely to become particularly problematic when the nurse interacted with other health care professionals and problems of demarcation and authority could occur. This is of particular relevance to nurse teachers as, the Registered practitioner has the authority within his/her practice area and so the nurse teacher as an outsider is without any authority if he/she wishes to exert her clinical responsibility.

<u>An alternative to the bedside role.</u>

Infante (1986) put forward the suggestion that the role of practitioner and of teacher should be performed separately since the caring and teaching role involves conflicting strategies and behaviours; conflict cannot be avoided when a role emerges from two basically different orientations such as those of nurse and educator. Infante (1986), proposed that with proper preparation for the role of nurse educator, conflict, ambiguity, and the resultant role stress can be reduced, conflict resolution and role definition and clarification can be greatly aided through proper preparation and initiation into this role.

Infante (1986) suggested that nurse teachers are the role models for teaching rather than for clinical practice, and argued that the "practitioner" of nursing in the various practice settings act as a role model for student nurses. Jones' study (1985) identified the ease with which nurse teachers took on a supportive / advisory role in practice settings and, in fact, Osborne (1991)

saw this as a strength which allows a new interpretation of "clinical credibility" to enter the arena - that of clinical liaison. Osborne (1991) suggested that nurse teachers should stop trying to remain clinically up to date (and often failing) and they should, instead, utilise and develop their educational skills in supporting ward staff to create a good learning environment for nurse students. Osborne, therefore, believed that the strength of the nurse teacher lay in the expertise that he/she could bring to the practitioners and the support that could be offered in assisting them to recognise the importance of the teaching and learning aspect of their role in relation to student nurses.

Fawcett & McQueen (1993) suggested that the interpretation of "clinical liaison" was facilitated by the ENB Guidelines (1988, para 2.2.3) when it stated that first level nurses should act as "supervisors, assessors and if possible mentors (of student nurses)". In view of this, nurse teachers could quite legitimately see their clinical credibility in terms of preparing, supporting and guiding these first level nurse practitioners. Indeed such changes could be seen to generate positive outcomes; theory would be related to practice; practitioners would be kept involved and updated as to the learning needs of students and nurse teachers could feel that they were still significantly, if indirectly, influencing the quality of practice based teaching.

Authors such as Windsor (1990), Clifford (1993) and Fawcett and McQueen (1993) identified that the main constraint preventing nurse teachers from teaching in the ward setting is that of time. They also suggested that the liaison role will be equally time consuming and requires commitment, and the nurse teacher will find no more time to liaise in the future, than she/ he did to teach in the past. However, it may be that, unlike clinical teaching which is found to be so stressful (Jones 1985), time will be found to liaise as it is perceived to create less stress.

The preparation and initiation of nurse teachers for a practice role.

Many of the reports published on nurse education eg. GNC 1954; RCN 1961; DHSS 1970: DHSS 1972) and RCN 1982 have recommended the need to regard the nurse tutor (teacher) as an educator in the widest sense, and that courses for the preparation of nurse teachers should include preparing them to teach in nursing practice settings as well as in the classroom.

Lancaster (1972) produced a report of an opinion survey which she conducted on all Registered nurse teachers, midwife teachers and health visitor tutors in Scotland about how nurse teachers should be prepared for their future role. Arising from that survey Lancaster (1972, p5) argued that the right kind of training depends on the definition of the teachers' role, since role can be shaped by the occupant, as well as by the expectations of professional clients and colleagues. But, as highlighted by my literature review, there is no consensus about the expected role of nurse teachers in practice settings and, consequently there has been ongoing debate about nurse teacher preparation and the adequacy or inadequacy of preparation courses. Lancaster (1972, p8) identified that "the question which seems to require urgent consideration is whether the present tutors' courses give them the kind of preparation which will enable future nurse teachers to cope effectively with the professional demands made upon them". And since then the nursing profession has been through many changes and, to me, the same question appears to be just as appropriate today as it was then.

The ENB (1990a, p27) commented that the nurse teachers have had a multi - faceted role which has never been clearly defined. This, I would suggest, is no different to the picture which was portrayed nearly twenty years previously when it was said that "the nurse teacher is expected to be maid of all work, teaching all the subjects in the syllabus (DHSS 1972).

The ENB (1990a, p33) suggested that nurse teacher students be given opportunities to maintain and develop clinical skills. But, I would argue that many current teacher education courses, in general, do not prepare them for such or allow them these opportunities. In the same ENB Report it was recommended that there should be an exploration of the role of the nurse teacher, the skills required to fulfil the role and the preparation for the role in future. But Crotty & Butterworth (1992) have highlighted that, whilst it is necessary for the preparation for the role of the nurse teacher to be determined, it also necessary for the provision of more resources for the continuing education of nurse teachers.

Elkan and Robinson (1995) reported that their review of the literature revealed the research findings point to much confusion and uncertainty about the teacher's role in practice settings. Much of the confusion, they write, about how great is to be teacher's input in the practice setting can be traced back to the UKCC's original Project 2000 proposals (UKCC 1987). The Project 2000 document contained little in the way of concrete and workable suggestions about how teaching staff might relieve practitioners of the share of the teaching which takes place in the practice setting, given teachers' other pressing demands and responsibilities. They suggest that it has been concluded from such research evidence as exists, that Project 2000 has thus failed to tackle adequately what has for many decades been one of nursing's most vexing problems, namely who is to teach students in the practice setting. Also how is such teaching to be organised, and funded, since the demise of the clinical teacher.

The background against which this piece of research is taking place is where the role of the nurse teacher is still yet to be conceptualised, and the preparation required for that role is still yet to be identified on a national basis. Therefore the problem, identified by Bowman in 1979, of how to prepare nurse teachers to function effectively in a rapidly changing social or

professional environment, still remains.

Key issues / questions arising from the literature review.

The literature review has revealed that there has been a persistent lack of clarity and consensus in relation to the clinical role of nurse teachers and the preparation for teachers to perform that role. This presents not only a problem to this College of Health but to other Colleges of Nursing / Health. Many reports and studies have recommended "an exploration of the nurse teacher, the skills required to fulfil this role and the preparation required" (Bowman 1979, RCN 1985, UKCC 1986, ENB 1990). Yet no firm proposals have been forthcoming. Indeed, the Statutory Training Body (ENB) charged with the responsibility for approving Teacher Training courses, from which a nurse gains a recognised Nurse Teacher qualification, have themselves failed to either identify the role required of a nurse teacher, the preparation needed for that role or the requirements for on-going development. In the mean time nurse teachers perform a role in practice settings without an agreed role specification.

Broad issues arising from the literature review which required exploration.

The literature review revealed issues that I felt it was necessary to incorporate into the research in order to inform the debate. These issues were incorporated into the questionnaires as a way of addressing the specific aims of the research as outlined on pages 4/5. The issues were:

* with the failure of the Statutory Training Body to identify the ongoing development of nurse teachers, how did the nurse teachers in this College identify and organise their own development in the light of the changes outlined in chapter two ?

* what did the role definers perceive as "clinical credibility" of nurse teachers in relation to the ENB's requirement (1993) for their "active involvement" in practice settings ?

* what is the definition of "active involvement", in relation to determining a future role in this College for the nurse teacher working in the practice settings ?

* who should have the responsibility for teaching student nurses in the practice settings ?

* Where role conflict, or the potential for role conflict, was apparent would it be possible to identify a strategy for its resolution ?

CONCLUSION

This chapter has outlined a literature review undertaken on the role of the nurse teacher in the context of role theory. The literature has revealed that there has been a consistent lack of clarity and consensus in relation to the clinical role of nurse teachers and the preparation for teachers to perform that role. Broad issues which required exploration were identified and incorporated into the research study. The way I handled this is outlined in chapter four on the methodology used for the project.

CHAPTER FOUR.

METHODOLOGY

The research methodology was predominantly action research, and was qualitative in nature although I used a triangulation of research methods which required both qualitative and quantitative methods of data collection and analysis methodologies. Triangulation may be defined as the use of two or more methods of data collection in the study of some aspects of human behaviour. Cohen & Manion (1989, p269) wrote that triangular techniques in the social sciences attempt to map out, or explain more fully the richness and complexity of human behaviour by studying it from more than one standpoint and, in so doing, by making use of both quantitative and qualitative data.

(a) A broad definition of action research.

Action research as a method of enquiry was first proposed by Kurt Lewin (1947, p202) when he described a research strategy that combined the generation of theory and brought about social change through action. Lewin placed great emphasis on research ideas (theory) put into practice. It has been described as an experimental approach, using social science methods and evaluation to support social science action (Meyer 1993).

Action research is a form of social enquiry where participants reflect on their own practices with a view to gaining greater understanding of those practices. Kurt Lewin (1946, p35) who described the process in terms of planning, fact finding and executing, documented the efforts of a collaborative decision in facilitating and sustaining changes in social conduct, valuing the involvement of participants in every phase of the action research process. Lewin considered the three important characteristics of action research as being its participatory nature, its democratic

approach and its simultaneous contribution to social science and social change. Two of the ideas which were crucial in Lewin's work were the ideas of group decisions and commitment to improvement.

John Collier (1945, p294) is another name connected with the legacy of action research. Collier brought together researchers, administrators and lay persons for the purpose of diagnosing problems and initiating action related to race relations. The emphasis here on the involvement and collaboration of researcher and practitioner in diagnosing problems, designing action plans and implementing these actions which became another central characteristic of action research. The involvement of the researcher and practitioners in the process of inquiry, deviates from the perspective of the researcher as a neutral observer isolated from the object under investigation. Therefore, action research is based on the philosophy that research should not be an esoteric activity indulged in by researchers in isolation from the people they study (Fay 1975, p88). Unlike more orthodox forms of research which may or may not lead to change in practice and social improvement, such collaborative enquiry is seen as a form of education, personal development and social action (Reason 1988, p74).

(b) The choice of an action research approach.

This piece of research was carried out under the assumption that it would be possible to define in collaboration with nurse teachers a role for them which was acceptable and workable in all practice settings. I chose an action research approach as the means of exploring this role in order to add rigour to the process of development and change, to illuminate actions and to monitor their repercussions.

But, in particular, it was chosen because Towell & Harries (1979, p198) placed particular

emphasis on the need for support resources for nurses who are trying to introduce changes in their work practices, and see action research as a means whereby staff can "take back authority for clarifying their own roles and working to establish the conditions required for effective task performance by themselves and others". This, to me, was an important concept for nurse teachers when assisting them to identify their role in clinical practice.

According to Cohen and Manion (1989, p218), the principle aims of action research are to improve practice. As the aim of this piece of research is to improve the practice of nurse teachers in clinical practice, Cohen & Manion's view confirmed for me the appropriateness of the use of this research methodology.

Carr & Kemmis (1985, p180) saw as the main strength in action research the improvement of teachers educational practices through their understanding of their own practices and the situations in which they work so that the action research is a form of research carried out by practitioners into their own practice. They suggest that three conditions are necessary for action research to exist. First "the subject must involve a problem in practice which is susceptible to improvement; this, I would suggest is the case for defining the role of the link teacher. An action research approach seemed appropriate for this research study because it does not demand that the project begins with the research problem clearly spelt out. "Diagnosing" involved myself as the researcher, nurse teachers, student nurses and practitioners working together to identify and clarify the research problem, a process which produced a number of interesting findings in its own right. As an action researcher, I considered that it was important to explore all sides of the story ie. from the point of view of the nurse teachers, as well as from practitioners, and student nurses.

Second, Carr & Kemmis (1986, p185) argued, " that the project is conducted in a cyclical fashion incorporating planning, action, observation and reflection". As this is the basis for the problem solving approach to the delivery of patient care, with which the teachers are familiar, it seemed appropriate to use this approach to the stated problem. Included in this cyclical approach is the diagnosing of a problem area, developing a plan of action, implementing the action plan and evaluating its effect so that the lessons learned can be applied to the original problem (Elliott 1991, p90).

Normally, in more traditional research, the researchers themselves do not implement change but generate findings and feed them back to the organisation to encourage discussion. This enables those within the organisation to make decisions about what changes are needed as well as when and by whom action will be taken.

And finally, "the project involves practitioners", and I support this philosophy, for without the involvement of teachers it would have been very difficult to bring about the desired change in their practice. The important principle of "involvement" was the collaborative involvement of the nurse teachers so that they became "involved" in the research process and participated in the decision making processes as opposed to being the objects of the research study.

Kemmis & McTaggart (1988, p10) highlighted that action research is participatory, collaborative research which typically arises from the clarification of some concerns shared by a group. This was the principle which I adopted throughout the research whereby I, as their manager, worked in collaboration with the nurse teachers to diagnose their problem, designing an action plan and implementing an agreed role in practice settings. Throughout the project, the concept of "volunteering" as opposed to management selection for a project of this kind, was an important

issue for me as "management is the exercise of power (Henry 1995, p22). The motivation to change is essential and inevitably the project, at times was stressful for the participants and, therefore, the coercion of staff to participate in the research project would have defeated the objective of collaboration.

In action research the researcher is usually directly involved with those being studied and because of its participatory nature, the participants also become researchers into their own problem. Through the participation of the nurse teachers in the research process they were assisted to research into their own practise in practice settings and to identify a solution to their problem.

From the available literature it is apparent that action research is becoming increasingly popular among nurse researchers. Hart (1995) re-iterated this view and explained that it is seen to offer a means of narrowing the gap between theory and practice, of promoting the development of the nurse as "researcher", and of empowering nurses and users to bring about changes in their lives and work. As such, I considered an action research approach to be ideally suited to this piece of research because it offers a way of narrowing the theory / practice gap by bringing nurse teachers and practitioners into close contact so that each may learn from one another and develop skills relevant to their work (Webb et al 1990).

Clarke et al (1993) argued that action research accounts should:

* be reflexive (That is, they should explain how researchers influenced the research process)

* highlight tensions and contradictions

* discuss how the data collection and analysis were conducted

* manage to "bring the situation to life" while discussing theoretical and professional themes

This view was re-iterated by Waterman (1995) and therefore taking the advice of these authors, this account of my action research project attempts to be reflexive, highlighting the inevitable effect which researchers have on theory production. I have also placed the research setting in context and have inserted quotes from the research participants to "bring my dissertation to life".

But what is meant by reflection ? Dewey (1933, p31) whose definition is one of the earliest and most quoted definitions saw reflection as :

> "active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and further conclusion to which it tends".

Schon (1983) identified two practicums to the process: reflection-in-action and reflection-on-action. He saw reflection-in-action as "reflection on phenomena and on one's spontaneous ways of thinking and acting, undertaken midst of action to guide further action" (Schon 1983, p49) whilst reflection-on-action is reflection after the event and reflection on the reflection-in-action (p52). It is these processes that elevate the action of the reflective practitioner above those of the technical expert. Reflecting on our experience builds concepts which are then tested through experimentation and experience, and so on. Schon (1983, p50) identified this process as a learning process.

Asking the teachers to reflect on their actions in carrying out a newly defined role was a way of testing out its legitimacy and acceptability in all specialist areas of practice. I will, however, note that this piece of research will be limited in its ability to be generalised. Essentially, it is a solution, an innovation, that is grounded in local issues and problems.

Criticism and defence of action research.

Action research is not without its critics and, as Castle (1994) cited in Hart (1995) pointed out, methodologically it may be challenged as being subjective and therefore lacking in reliability and validity. Because it is essentially problem-solving and context-specific, it may not be possible to generalise the findings. Hodginson (1957, p146) questioned whether action research is really research as there is a debate in terms of its rigour. But as Hart (1995) argued action researchers, however, do not make claims so much on the grounds of scientific rigour as in terms of generating findings which are useful and relevant. It is the focus on improvement of practice and on collaboration between participants to achieve, sustain and learn from such programmes of change which make it attractive as a research methodology for nursing.

Husen and Postlethwaite (1985, p39) articulated that:

> "the rigor of action research does not derive from the use of particular techniques of observation or analysis or the use of meta-techniques. Rigor derives from the logical, empirical, and political coherence of interpretations in the reconstructive moments of the self reflective spiral and the logical empirical, and political coherence of justifications of proposed action in its constructive or prospective moments (planning and acting)"

(c) Qualitative research methods.

As the research method was mainly of a qualitative nature the theoretical concepts from authors such as Bogden and Biklen (1992), Hammersley and Atkinson (1983 rep. 1993) and Burgess (1984 rep. 1993) were used to underpin the argument. Thus by using a qualitative approach it allowed me to learn about the world of link teachers and their link areas at first hand. These authors argued that qualitative methods allow researchers "to get close to the data" and provide opportunities for them to derive their concepts from the data that is gathered. The style of the approach is, therefore, exploratory rather than hypothesis testing and based on interview and

interaction.

The term qualitative research refers to systematic subjective studies that describe and give meaning to people's life experiences (Burns & Grove 1987, p81). The choice of a qualitative approach to the role of the nurse teacher in practice settings reflected the need for data about their lives that could not adequately be described purely in numerical or statistical terms.

A qualitative stance was chosen because of the strength of argument put forward by Holloway (1991), in that "qualitative research methods involve an understanding of human experience by professions which focus on care, communication and interaction", this then appears the natural method to be adopted for the analysis of the role of the link teachers in clinical settings. The strength of qualitative approaches to research lies in the discovery of the perspectives of research subjects and the meanings and interpretations which they give to events and actions (Field and Morse 1985, p122).

(d) The research in action.

The research was conducted using Kurt Lewins' action research approach, as described by Kemmis and McTaggart (1988) based on Lewins' (1946) model. Each spiral is made up of four areas of activity that of planning, acting, observing and reflecting which involves:

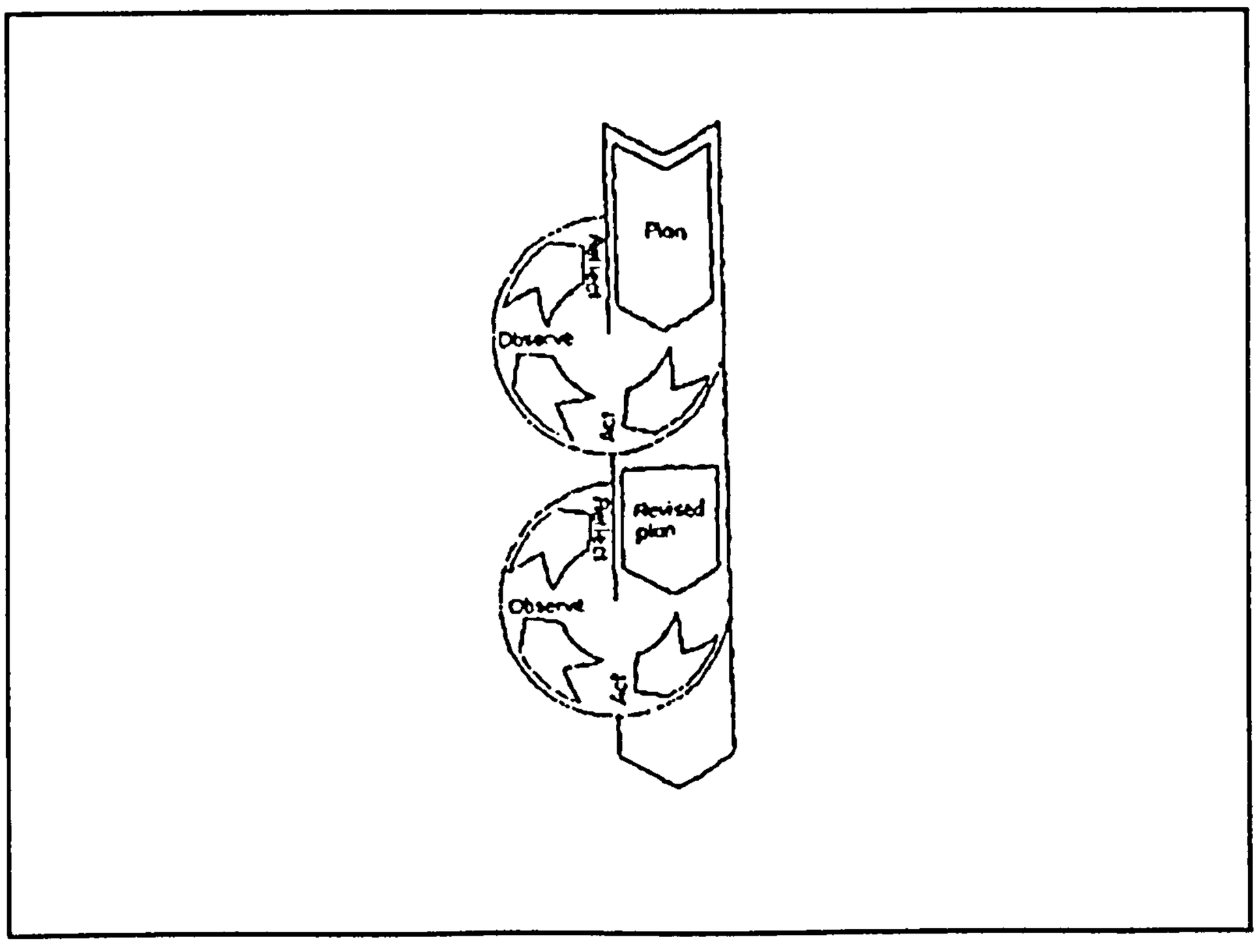
Planning some actions that will clarify workplace problems and might also help to improve the situation.

Taking action to carry out the plan with the other people who have helped to formulate it.

Observing the impact of your action on the situation of interest.

Reflecting on the outcomes as a way of deciding what actions to take next.

Figure 1 The action research spiral (Kemmis & McTaggart 1988); used by permission of Deakin University Press, Victoria.



Recording the research activity.

Throughout the research any field notes that I made or interview transcripts recorded were supplemented by a journal in which I wrote my personal feelings, progress and ideas about where to go next, thereby generating analytical notes. Thus, analysis was not a discrete stage but was done concurrently with data collection.

STAGE ONE - PLANNING.

Stage one involved clarifying with the nurse teachers in discussion groups, their concerns in relation to the lack of role clarity in practice settings and involving them in a collaborative approach to identifying the areas which needed to be explored in order to define a role for them.

It also involved identifying groups of role definers and designing appropriate tools for obtaining the relevant information from the role definers on their views for a role for nurse teachers in practice settings. And then analysing the findings to identify a proposed role for nurse teachers which could be trialled in a range of practice settings.

(i) Selection of the role definers.

Morse (1991) pointed out that participants should not only have experienced the phenomena under consideration but should be able to articulate their thoughts and feelings. Three groups of role definers stood out to me as obviously needing to be included in the information gathering process:

- a sample of nurse teachers
- a sample of practitioners with whom they link in the practice settings
- student representatives who have their clinical experience in these practice settings

Arising from ideas gathered from the nurse teachers I designed separate evaluation assessment tools for the collection of qualitative and quantitative data from the three groups of role definers. These being, a student questionnaire and semi-structured interview schedules for teachers and practitioners. A key feature in developing the information gathering tools was to focus on the perceived role of nurse teachers in practice settings.

I support the premise that any research involving human subjects should be subject to ethical approval (Royal College of Physicians 1984), I therefore subjected my research proposal and questionnaires / semi structured interview schedules to the Nurse Education Departments' Ethics Committee for approval.

Student representatives.

Students' opinions were collected through the use of an open-ended structured questionnaire (Appendix 3) administered whilst they were in College. The use of face to face interviews with students was not considered appropriate because of the power relationship between the student nurses and myself. Also the number of students involved in the task would have proved too time consuming.

A cohort of student nurses, numbering 128, in the last six months of their training was selected to participate in the research. This cohort of students had had more clinical experience than the remaining cohorts in training and, therefore I considered them to be in the best position to make judgements about the support they required in practice settings.

The questionnaire was piloted with a small sample of student nurses from another cohort who volunteered to participate once the rationale for the research had been explained to them and assurance of anonymity given. Analysis of their responses identified ambiguity in some of the questions. Following rewording, the questionnaire was then distributed to the selected cohort for self completion.

One hundred and twenty eight questionnaires were distributed to the September 1991 entry date cohort (term 7/8) students whilst they were in College. The rationale for the research was explained to them and assurance given of anonymity. Each of the Branch teachers with the responsibility for the students on that particular day was asked to distribute the questionnaires. The teachers were also given the option of whether or not they should supervise the students while they completed the form. Student participation in the research was not compulsory.

(Figure 2) Student response rates.

Branch Students	Number of questionnaires distributed	Number returned	Response rate
Adult	86	50	58 %
Child	13	9	69 %
Learning Disability	14	13	93 %
Mental Health	15	6	40 % *
Total Population	128	78	61 %

* denotes students not supervised

Teacher representatives.

Views on the role of the link teacher were sought from twenty four nurse teachers. I considered it essential to obtain responses from teachers with as wide a range of clinical responsibility as possible, in order to test out the applicability of a defined role to all types of experiences to which students are allocated. Because there are fewer nurse teachers in the smaller Branch Programmes I, therefore, approached all teachers concerned with these three Branch Programmes ie. seven from the Child, six from Learning Disability and four from the Mental Health Branch Programme. Selection of the participant teachers from the Adult Branch was by a nominal list of seven teachers selected by the Branch manager. Representatives with responsibility for Community experience were included in the list of Child and Adult Branch teachers. Sixteen (66%) of the nurse teacher representatives had been involved in the debates on the role of the nurse teacher in practice settings.

On an individual basis I explained to the twenty four teachers the outline of the research project, assuring them that their responses would be treated in confidence. All teachers subsequently agreed to participate. During the interviews I was aware of the power relationship between us, but judging by their responses this did not appear to have inhibited their answers.

Practitioner representatives.

The research proposal was presented to, and discussed at a meeting with, Chief Nursing Advisers of the local N.H.S. Trusts. Permission was sought and given to approach some of their Registered Nurses who have the responsibility for teaching and assessing student nurses in practice settings, to seek their views on the role of the "link teacher".

In order for me to select appropriate practitioners, the sample group of teachers were asked to identify a range of practice areas to which they linked. Student nurses from the Child and Learning Disability Branches gain experience outside of the N.H.S. settings eg. Local Authority Schools for Children with a Learning Disability, therefore, Teachers from "Special Education Schools" were included in the sample group. Their responses were not analysed separately but included them in the total number of practitioner responses. A total of twenty four practitioners were selected from the corresponding practice area to which each teacher linked.

A letter was sent to the practitioners explaining the purpose of the research and asking if they would be willing to participate. Ninety two percent (22) were willing to participate but the other two considered that it might be too time consuming and therefore declined. Two additional practitioners were contacted from the relevant areas who subsequently agreed to participate following explanation of the purpose of the research.

(ii) Data collection instruments.

I obtained the views of volunteer teachers and practitioners through the use of a semi-structured interview schedule (each designed appropriately for the respective respondent group - Appendix 4 & 5) on which I recorded their responses to the questions posed by hand as many of the respondents did not wish to have their responses tape recorded. The interview with each teacher lasted approximately one hour and approximately three quarters of an hour with each of the practitioners. Each respondent was given the opportunity to look back over what I had recorded from their interview schedule in order to check for authenticity.

I saw the main advantage of using semi-structured interview schedules as being their flexibility. During the interviews many of the respondents said something interesting which was worth exploring further and I was, therefore, able to pursue the topic which would not have been possible had I used a questionnaire approach.

Also, I preferred to use face to face interviews with these two groups of participants as I believe that, by using a personal approach it would draw out more of their informed thoughts. Reflecting on previous personal experience, this approach does obtain richer results. But access to participants did present problems, in particular to the practitioners especially when their shift times changed or emergencies occurred whilst I was interviewing the participants.

The appropriate interview schedules were piloted by two volunteer teachers and three practitioners working in a variety of settings. Analysis of the findings identified that adjustments to some of the questions on both schedules were necessary.

(iii) Analysis of the data.

The analysis of the information was conducted by two methods. The quantitative data was analysed through statistical analysis but the qualitative material required a more appropriate method.

The use of semi-structured interview schedules can lead to problems in deciding how to analyse the transcripts once the interviews have been completed. Therefore the method that I used was a thematic content analysis. The aim was to produce a detailed and systematic recording of the themes arising from the content analysis of the data.

The material obtained from the students' questionnaires and written interview notes from the teachers and practitioners was also analysed, in addition to a quantitative analysis, in stages using techniques described by Hycner (1985) and Burnard (1991). Hycner's method applies specifically to phenomenology and concentrates on "reduction" of the utterances of the participants. This reduction is not intended to distort or trivialise the account by removing any thing from it rather, to distil the essence of perceptions such as small quantities of perfumed oils are distilled from tons of flowers.

The aim of the analysis was to produce a detailed and systematic recording of the themes and issues addressed in the interviews and to link the themes and interviews together under a reasonably exhaustive category system. As Burnard (1991) pointed out herein lies the first problem that the researcher must remain aware of, to what degree is it reasonable and accurate to compare the utterances of one person with those of another ? Are "common themes" in interviews really "common" ?

I started the process with eliciting units of general meaning in order to get a sense of the whole of each interview. I began the rigorous process of going over my notes of each interview in order to crystallise and condense what each participant had said, still using as much as possible the literal words of each participant. The result of this is called a unit of general meaning. Hycner (1985, p282) defines a unit of general meaning as "those words, phrases, non - verbal or para - linguistic communications which expresses a unique and coherent meaning clearly differentiated from that which precedes or follows". Once I had noted the units of general meaning I addressed the research question to the units of general meaning to determine whether what each participant had said responded to and illuminated the research question.

When I had completed the above steps I looked over the units of relevant meaning and eliminated those which were clearly redundant. I then tried to determine if any of the units of relevant meaning naturally clustered together to identify whether there were some common theme or essence that united several discrete units of relevant meaning.

Finally, I interrogated all clusters of meaning to determine if there were one or more themes which expressed the essence of these clusters. Once all the above steps had been repeated with each individual interview, I began to look for themes common to most or all of the interviews as well as the individual variations. These themes were then clustered together as indicating a general theme that emerged in most or all of the interviews.

All data for each respondent group was analysed according to the Branch specific sub groupings in order to identify consensus or diversity of opinions across all areas of practice. Generalised analysis alone could not assume that consensus would be present from all four sub groups (ie. Adult, Child, Learning Disability and Mental Health) and therefore assumptions on any agreed

role for the nurse teacher in the future could not be made without this in depth analysis.

In any analysis of qualitative data there is the problem of what to leave out of an analysis of a transcript. Ideally, all of the data should be accounted for under a category or subcategory (Glaser & Strauss 1967, p23). In practice there are always elements of interviews that are unusable in an analysis. Field & Morse (1985, p113) refer to this data as "dross". In order to illustrate how themes emerged and what theme was not included in the analysis of the interviews an example of part of the process in given below:

Question posed to the teachers and practitioners - "What do you consider the role of the nurse teacher to be in practice settings ?

One of the teacher's responses	Open coding
Primary role is to be a strong link between the educational department and the clinical area as this is the main line of communication. Because without that separation can occur and student can be distressed.	strong link between educational department and clinical area main line of communication
Communication link must be strong with the clinical staff.	communication with clinical staff
Ward auditor.	ward auditor
We are jack of all trades but master of none and so we must have a high profile in the clinical area because we are the theory / practice gap buffer / closer.	high profile theory/ practice gap buffer/ closer
Teachers also bring reality back into the educational process as practice is ultimately what you are providing the service and so there needs to be reciprocal contact.	reality

In order to address the aims of the research, as outlined on pages 4/5, I was seeking to address the concept of consensus in relation to the opinions arising from the three sets of role definers on a proposed role for nurse teachers in practice settings. Gross et al (1966, p213) addressed the issue of consensus when they explained that "the degree of consensus on the expectations

from each alternative can be inferred from the percentage who feel that any actions would be approved". For the purpose of this piece of research, I inferred that consensus existed when there was at least 75% agreement on any of the responses to the identified questions in the questionnaires/ semi-structured interview schedules. Throughout the remainder of the documentation this will be indicated in the tables by an asterisk.

Following my analysis of the data I fed back my general ideas to the teachers and practitioners. I discussed, separately with representatives from the participant teachers and practitioners, the emerging themes for authenticity. I wanted them to clarify and confirm for me whether the data was there to support the emerging themes or whether they emerged because I wanted them to emerge. Both the teachers and practitioner confirmed the emerged themes from my analysis of their responses had in fact had validity because they reflected their views. The themes identified a role for nurse teachers in practice settings as primarily being a support to the practitioner in order to enhance the practice learning environment in support of student nurses. This role differed to the one outlined in the course document (A&GCoH 1990, p48) in that it involves enhancing the practice learning environment and assisting the practitioners to link theory to practice. This is opposed to the one which focuses only on preparing practitioners for mentoring and assessing role.

STAGE TWO - TAKING ACTION TO CARRY OUT THE PLAN.

Stage two involved taking action to change the practice of nurse teachers which commenced with negotiations with nurse teachers for volunteers to trial the role of an educational facilitator in one of their practice areas. Thirteen teachers working from a range of practice settings volunteered to pilot the role for at least one day per week for a minimum of twelve weeks. This period of time included any pre arranged annual leave or attendance at conferences.

A meeting was held with managers of local NHS Trusts to negotiate with them the trialling of the role in thirteen relevant practice settings.

STAGE THREE - OBSERVING THE IMPACT OF ACTION ON THE SITUATION OF INTEREST.

Structured diaries (appendix 8 and 9) were designed in which the nurse teachers and practitioners were asked to record their reflections on aspects of the proposed role. I designed a structured format for their use as Burgess (1990, p129), pointed out that when a number of informants are asked to keep diaries, these diaries may vary in depth and detail and this may make comparison and analysis difficult for the researcher. The use of a structured diary allows the researcher to compare and code entries (Gibson 1995). I decided upon the use of diaries since they could provide me with the opportunity to gain insight into personal intimate situations. Burgess suggested that diaries provide the researcher with a first hand account of a situation that they might otherwise not have direct access to and he cited his own work with teachers as an example. I decided against directly observing the teachers in the practice settings as not only would it have been too time consuming, but it would have been difficult for me to judge what changes in behaviour / relationship with practitioners had occurred. Also, the teachers could have been reluctant to let me, as their line manager, observe them which could have interfered with the collaborative relationship which had been established between us.

The recordings in the diaries were analysed and codified by the use of Hycner's (1985) and Burnard's (1991) methodology as outlined in stage one.

Meetings were held with representatives of the teacher and practitioner respondents to discuss and validate the findings with them.

A proposal for a protocol for the role of an educational facilitator was submitted to the Faculty's Executive Management Group for their consideration for action.

STAGE FOUR - REFLECTING ON THE OUTCOME AS A WAY OF DECIDING WHAT ACTIONS TO TAKE NEXT.

This involved the evaluation of the process and the outcomes of the research and in the light of this making recommendations to the Faculty Management Executive Group for consideration.

(e) Ethical issues of being a manager / researcher.

Similar ethical principles apply to both "traditional" and action research approaches (Waterman 1995). These include respect for research participants, prevention of harm, assurances of confidentiality or anonymity and maintenance of privacy (World Medical Assembly 1975). I feel that it is vitally important when undertaking action research to share the ongoing reports with the participants to ensure they are assured their contribution or personal involvement cannot be identified from the report. Elliott (1978, p126) emphasised that, since action research involves unconstrained dialogue between "researcher" and participants, there must be free information flow between them. Elliott explains that this is why action research cannot be undertaken properly in the absence of trust established by fidelity to a mutually agreed ethical framework governing the collection, use, and release of the data.

As a manager undertaking the research I was aware that the ethical issue was just not one of informed consent and also confidentiality, but also the manner in which I, as the manager, would handle the data I gained. Whist I had the obligation to "tell it as it was", there was a risk that teachers would suspect that the information gained could be used against them (Finch 1984).

Validity is essentially an ethical concern relating to trustworthiness. Action researchers have to make sure the quality, value, and honesty of their enquiries are not jeopardised by unrecognised bias and influence (Titchen 1995). Titchen explained that action researchers have a very difficult task of ensuring their own bias does not colour their understanding of other's realities, at the same time as deliberately using it constructively to influence the reality being studied. But Titchen agrees that all actors must use their bias, beliefs and values in their action, if they did not they would not be able to act. It would have been impossible for me to help nurse teachers change their practice in clinical settings if I had not believed that their role could not only be performed more effectively, but also that this would increase their satisfaction. I was using my bias consciously to realise my values in action, but I also wanted to evaluate the effectiveness of my actions from their perspective, and represent their experience in my theoretical account.

As highlighted by Titchen (1995) alternating between these two positions requires a high level of self-awareness and skill. By making their bias, beliefs, experience and knowledge explicit, at least to themselves, action researchers are more able to suspend them to grasp the multiple realities. My perception of my success or otherwise of me managing these two positions (that of manager and of researcher) is carefully monitored and documented in field notes as part of a test of rigour, namely self validation.

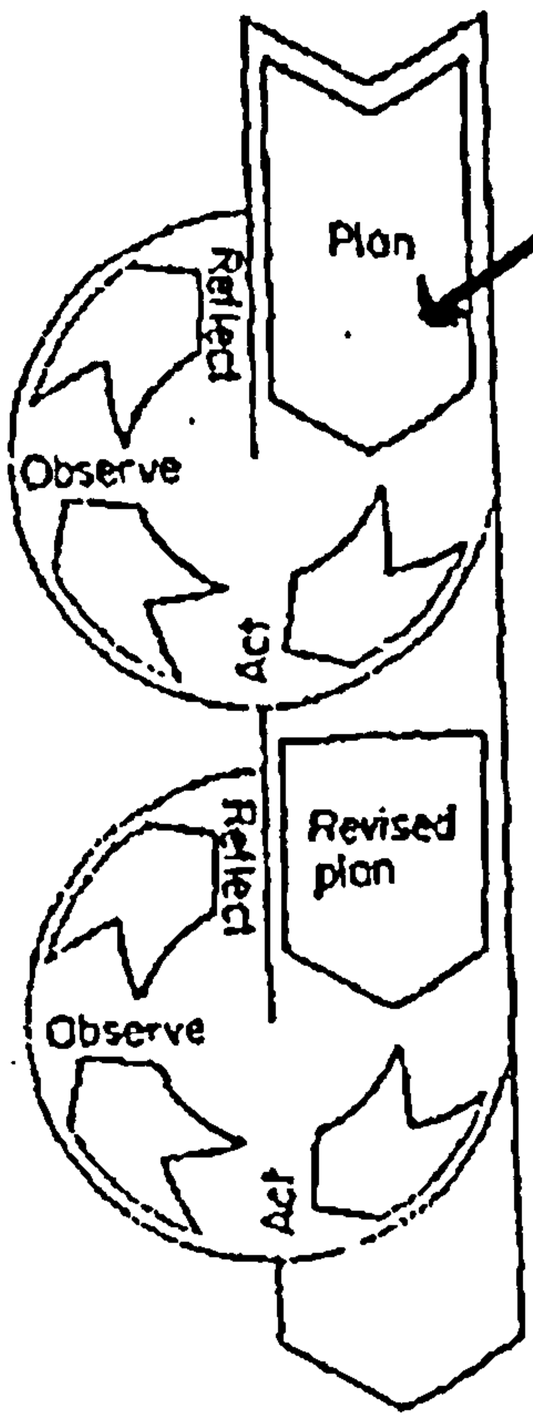
For example, during the fact finding stage, a ward sister described to me her frustration at not being able to get the link teacher to come to her ward to support the student nurses. She obviously wanted me to act in the "manager" role as opposed to my role as a researcher. I had to be very clear about which role I was in and when, in order to record her perceptions of the role of the link teacher in clinical practice, before making an explicit attempt to influence her thoughts and feelings.

There is also an ethical obligation for researchers to show the reader that they recognise the effect they had on the participants. From the beginning it became obvious to me that the research must not appear to be "management led", as my authority in the position as line manager created an unequal power relationship with all of the three groups of participants, but especially with the nurse teachers. In anticipation that my position as a Senior Education Manager might have triggered anxiety in nurse teachers, I was prepared to try to balance being a "sympathetic listener" (Webb 1989) and remaining neutral. It was important that I made it clear that teachers should not feel obliged to participate in the research because I was their manager. I made it explicit that I was not going to use my position of authority to force innovation upon them or to tell them what the role should be, but rather any changes would be democratically negotiated as a result of my findings.

CONCLUSION.

This chapter has outlined and justified a collaborative action research approach to defining a role for nurse teachers in practice settings. It further described the action taken in each of the four stages of the first action cycle. The following chapters describe more fully the processes in which I was engaged at each of the stages, commencing with the next chapter which outlines the planning stage where the "problem was clarified" and steps taken to "improve the situation".

CHAPTER FIVE
STAGE ONE - PLANNING FOR ACTION



1. PLAN some actions that will clarify workplace problems and might also help to improve the situation by:

(i) Clarifying with teachers their concerns re their role in practice setting

(ii) Selecting role definers

(iii) Designing appropriate tools for obtaining relevant information

(iv) Analysing information obtained through use of Hyner's (1985) method

(v) The emergence of a proposed role of educational facilitator

(vi) Confirming proposed role with teachers and practitioners

The project began with the planning stage. This involved first, some reconnaissance about the problem and second some specific information gathering as outlined in chapter four. The information gathered was then analysed to arrive at a consensus view with the role definers on an acceptable and workable role for nurse teachers in practice settings.

(a) Reconnaissance

Fifteen nurse teachers (approximately one sixth of the total teacher population in the College) had on a previous occasion formed a "link teacher interest group" and had attempted to clarify for themselves their role in practice settings. They had met on three occasions but, as these events were not providing any answers, only more questions, they decided to postpone further meetings. The group agreed to meet again when I informed them of my interest in attempting to address this complex issue. Having formulated some ideas (appendix 2) about some of the issues which needed exploration I presented them as a basis for discussion. I considered it necessary to provide a "sympathetic ear" (Webb 1989), but I was aware that I needed to be cautious so that I did not lead the teachers to expect that I could provide them with immediate answers / solutions. Two meetings were held with them, with a total of twenty teachers attending to explore and discuss the issues outlined in appendix 2.

They expressed their concerns about their job which were caused through the lack of role clarity. These debates confirmed for me that there was a problem which required investigation and that my original view was still on track. During our two meetings it became evident to me that, as the educational manager, there was a need to clarify and strengthen the role of the "link teacher", in order for teachers to have credibility in the practice placement areas and also to make the most effective use of their time. I discussed with them the idea of their involvement in researching a locally defined role for nurse teachers in practice placements, so as to make it

a more meaningful role, not only for them but also, for students and practitioners. I discussed with them using a collaborative action research approach, as opposed to them being the passive recipients of the findings. Their involvement was essential, as without it, it would have been very difficult to have achieved a consensus view on a role for nurse teachers in practice settings. As the teachers were keen to have their role clarified they agreed to participate.

Reflection on my action at this stage of the research.

I considered that the meetings held with the teachers had provided an excellent base line for us to share the underlying causes of their problems and to agree an action plan on the way forward. The "openness" of our debates had developed a relationship of trust between us which resulted in them agreeing to move forward in a mutually collaborative way. Although the nurse teachers were not directly involved in the design of the information gathering tools, they did identify the areas of enquiry that they considered should be included in them. These were:

(i) the existence or non existence of a perceived theory/ practice gap in the delivery of the curriculum

(ii) the meaning of "credibility" in relation to the role of nurse teachers in clinical areas

(iii) identifying who should have the responsibility for teaching the students in practice areas

(iv) identifying and agreeing a role for nurse teachers in practice settings.

(b) Information gathering

The information gathered from the student questionnaires and the teacher and practitioner semi-structured interview schedules were analysed as outlined in Chapter four.

(c) Analysis of the information

A. DATA OF SPECIFIC RELEVANCE TO THE STUDENTS.

(a) Expectations of the student at this stage of training.

From the students' responses it was apparent that students in the Adult, Child and Learning Disability Branches depended very much upon the link teacher for support and advice. The Mental Health students appeared to feel much more confident, however, it was important to them that the link teacher was accessible if they needed help and support, and to give them guidance in ensuring that all necessary experiences were gained from each clinical experience.

Figure 3. Branch specific student expectations for and satisfaction with teacher support in clinical settings

Branch Numbers of Respondents		Percentage of students who expect support from nurse teachers		Percentage satisfied with nurse teacher support		Percentage dissatisfied with nurse teacher support	
Adult	50	80%	(40)	16%	(8)	84%	(42)
Child	9	38%	(4)	89%	(8)	11%	(1)
L.D.	13	31%	(4)	77%	(10)	23%	(3)
M.H.	6	16%	(1)	83%	(5)	17%	(1)

The level of satisfaction expressed by the students over the perceived amount of support given by nurse teachers was an area in which there was a great variation between the students from the four different branches. Although students were only asked to comment in relation to the support received from the link teacher in their last clinical placement, all of the Adult Branch students took the opportunity to express their views on the variation of support received throughout the whole of their training. Their responses appeared to give an indication as to their perception of link teachers' attitude towards the link role; "she came for a 5 minute chat which

was rushed - just to check that I was happy"; "some teachers appear to regard this as an unimportant role, with infrequent visits and no wish to work with the students"; "unapproachable due to the busy image portrayed"; "the link teacher doesn't seem to be bothered, you have the impression that you are on your own". Of those who were satisfied they were impressed that they were visited regularly and were given a lot of support and relevant tuition.

The Child Branch students were, on the whole, much more complimentary about the support given by teachers. The only student who reported that she was not satisfied with the level of support received said she felt this was because "she is also link teacher to Post-Registration students who, in her opinion are given priority".

Although the Mental Health students expressed a high degree of satisfaction with their perceived level of support their comments, in fact, appeared to relate to the support given by clinical staff in these areas as several of the students wrote "I haven't felt the need for great support from link teachers, much more support has been gained from clinical supervisors and key workers". The one student who expressed dissatisfaction with the perceived level of support received from the teacher did not appear to have been disadvantaged in that situation as he/she wrote, "no support as such from the link teacher, we had to rely on our key worker for support - which I feel was excellent".

The Learning Disability students recorded their satisfaction with the link teacher through expressions such as "invaluable advice was given when I needed it to sort out worries over "in ward" politics and how it affected the client, and what action to take".

As seen by figure 2 there is a high correlation between the percentage of students who expect regular visits from nurse teachers "just to give them support" and the level of dissatisfaction when this expectation is not met.

Therefore for these role definers, their "role expectation" is not being matched by the "role performance" of the majority of the teachers. It has emerged that an expectation from the student, is that the nurse teachers should visit and give support, but that very few students actually wanted link teachers to assist them with the delivery of direct patient care.

B. DATA OF SPECIFIC RELEVANCE TO TEACHERS.

(a) Profile of teacher participants.

Teaching experience of the teachers for the whole of the sample group ranged between eighteen months to eighteen years. Twenty one of the teachers had previous experience, either as a Clinical Teacher, or as a Field Work Teacher, prior to undertaking a course to become a Nurse Teacher, and would therefore have experienced teaching / supporting in clinical areas.

Only three of the seven Adult Branch Teachers are linked to clinical specialities for which they had experience prior to becoming Nurse Teachers. Of the Child Branch, three had been working in General Nursing prior to becoming Paediatric Nurse Teachers. The Mental Health Team do not have responsibility for specified areas of practice, but for geographical areas and are, therefore, responsible for several areas of specialist clinical practice. Five of the Learning Disability Team link with areas in which they developed expertise prior to becoming Nurse Teachers.

Of the twenty four teachers interviewed, only one of them had responsibility for clinical areas

in which there are students from only one term of the programme. The other twenty three teachers link with areas in which there are students from more than one term (ie. 2 or 3). This can have implications for the teacher if he/she has not had teaching input into all of these terms, when attempting to link the theoretical content taught in the College to the delivery of patient care in practice settings. Teachers have been allocated into, either the Common Foundation Programme Team, or a Branch Team, plus one or two Theme Team(s) with possible added responsibility for organising a term's programme. With such diverse arrangements for the delivery of the curriculum, it is impossible for any one teacher to have an overview of the whole programme.

(b) Teachers clinical visit details

Figure 4. Clinical visit details expressed in averages.

Teachers	No of clinical areas per teacher	Average number of students to support	Frequency of visit	Time spent per visit to each placement area
Adult	3/4	16	Once per week	2½ hours
Child	2/3	12	At least once per week	Half a day
Community	25	25/30	At least one visit per placement	½ to 1 hour
Learning Disability	25	25/30	At least one visit per placement	1¼ hours
Mental Health	19	19	Once per week	½ to 1 hour

The determination of the frequency of teachers' visits to the clinical areas, and the length of time spent on each visit varies according to the number of clinical areas which a teacher has to visit, and the number of students for whom a teacher has responsibility at any particular time. There appears to be a direct relationship between the number of clinical areas for which a link teacher has responsibility and the frequency and the duration of the visit (see figure 3).

However, each speciality group of teachers have their own complexities to cope with in each of their areas. Because of the diversity of the service, there is a tendency for only one student from one term of training to be allocated to each of the practice areas in the Community, Learning Disability and Mental Health settings. Therefore these teachers spend a significant amount of time travelling to and from each placement area. Whereas the education and training for Adult and Child Branch students is concentrated within institutional settings and therefore, each of the specialist teachers have relatively fewer placement areas with which to link. But, because of the concentration of the service on one site, there are more students on each of these placement areas and from a range of stages of training. Therefore, these teachers have the problem of how to link up with these students who are working different shift patterns and have different learning needs according to the stage of training they are at. But what is not evident is the exact role each of these teachers were performing in their placement areas.

It also became apparent to me that, the choice and number of placement links had not been a delegated responsibility from their line managers but had been arrived at by individual teacher choice and by the teachers' desire to protect their professional boundaries. For example, the Community teachers insisted that it was their responsibility to link with all of the community placement settings which included areas caring for children, for example nurseries etc. They did not consider it appropriate for the Child Branch teachers to have this responsibility as "their

training only prepared them to work in hospital settings". In addition, I found that there was some duplication of effort, as teachers from more than one Branch Programme visited the same placement areas to visit student nurses from different Branch Programmes. This occurred, particularly, in Local Authority Schools for children with Learning Disabilities. The Learning Disability teachers visiting their students and the Community teachers visiting the students from the Adult and Child Branch students. These factors were obviously contributing to the apparent imbalance of work loads.

This revelation confirmed for me of the necessity to identify an agreed and workable role for nurse teachers' in all practice settings in order that all role definers are aware of the teachers responsibilities. Also so that more effective use can be made of the teachers time, not only in relation to their responsibilities in practice areas but, also in relation to the other aspects of course delivery such as classroom teaching, marking scripts, research etc.

(c) Teachers suggestions for teaching in the clinical situation.

These suggestions from the interviews were based on what the teachers perceived as being possible in each of the specialist areas of practice. All of the teachers were adamant that there must be acknowledgement of the E.N.B.'s requirement (1993, section 2) for them to work the equivalent of one day per week in practice settings and therefore time must be tabled into weekly programmes.

Several of the Child and Adult Branch teachers identified working with students as a way of teaching in the clinical settings, but this method does not appear a viable proposition for teaching in the other specialities of Community, Learning Disability or Mental Health settings. The teachers reporting that these specialities are about building up relationships, and so going into

an area to work is like being a "loose cannon". From the teachers' responses it is obvious that they must use a variety of methods for facilitating learning, and they have an expectation of being able to facilitate that learning when visiting their practice areas. But these expectations can be thwarted by identified situations such as: (i) non availability of student (ii) crises occurring within the clinical area (iii) non interest shown by students in their non Branch area of practice (iv) workload in College and (v) "busyness" of practitioners.

C. DATA OF SPECIFIC RELEVANCE TO PRACTITIONERS.

(a) Profile of practitioners.

All practitioners interviewed had considerable experience ranging from 8 to 32 years, the majority specialising for a long period of time in the areas of practice in which they were interviewed .

The allocation of students from more than one Term is more likely to occur in clinical areas in which students from the Common Foundation Programme are gaining experience, in order to meet the E.N.B.'s Statutory Training requirements. The number of placements available for use in some of the specialities is limited, thereby putting pressure on the clinical areas when the relevant Branch students also need to gain experience in the same area. This has resulted in many of the respondents quoting that "they were unsure of the needs of the students at the different stages in their training and often it was from the students that they find things out".

D. DATA ANALYSIS OF RELEVANCE TO ALL ROLE DEFINERS

(a) Teacher clinical updating.

(i) Teachers views

All of the teachers (100%) agreed that it is necessary for them to be updated in clinical practice,

but they suggested that it would be hard to achieve full "clinical credibility" in the areas in which they have not had previous experience of working prior to becoming a Nurse Teacher, especially given their time constraints.

Of the twenty four teachers interviewed, 91% (22) became Nurse Teachers prior to the introduction of many of the philosophies of care which they are required to teach in the College eg. nursing process, nursing models and primary nursing. Teachers from all Speciality backgrounds identified that practically the whole of the curriculum has changed since they had taken up teaching. In the words of one teacher "the mind boggles, I think that if I could start all over again and do Project 2000 training, that would be very useful".

From the teachers' responses, it is apparent that they have had to put an incredible amount of effort into updating theoretically to stay ahead of the students whilst preparing for and teaching the Project 2000 programme. There has been pressure for the teachers to update their theoretical knowledge and now explicit within the E.N.B.'s Document (1993 - para 3.2), there is pressure for them to update clinically.

If, as identified by the teachers, they only have the theoretical knowledge of the nursing process and the use of nursing models, and not the expertise of practical application, this could be an underlining cause of the problems identified by some of the students. Students reported that teachers "were far too idealistic in their teaching related to the delivery of patient care" and identified a tension between the "ideal" and "reality".

<u>(ii) Practitioners views.</u>

There was no commonality of response to the questions about the necessity for teachers to be

clinically up to date or how they could be assisted to do this. One practitioner from the Adult Branch did not consider that it was possible for teachers to become clinically up to date in her highly specialised area, and if the link teacher was to teach in her area she considered that it could only be in the context of an academic session eg. linking of biological sciences to a patient's condition.

Child Branch practitioners generally agreed that teachers should work in the clinical settings on a regular basis, but also agreed that the teacher would never be as "clinically competent" as them.

The majority of the Learning Disability and Mental Health respondents were not sure of the ethics of teachers working in their area of practice because of interfering in the inter personal relationship between the practitioner and client. Instead, there was the suggestion that updating could be achieved through attendance at ward/ home meetings and generally, and having more meetings with the managers to familiarise themselves with what is happening in practice.

(b) Views on the responsibility for teaching students in clinical settings.

Figure 5

Role Definers	Teacher responsibility	Practitioners responsibility	Joint responsibility between teachers and practitioners
Student views (78)	None	60% (47)	40% (31)
Teacher views (24)	None	100% (24)	None (0)
Practitioner views (24)	None	66% (16)	33% (8)

Those students who considered that it was the responsibility of the clinical staff to teach did so because "they were the people who were there all the time and knew the patients/ clients best"; whereas those who considered it to be a joint responsibility between the link teacher and the clinical staff was because "clinical staff have the up to date practice experience and the teachers the up to date knowledge and therefore able to fill in on theory". However, many of the students perceived practitioners as either being too busy, or lacking in ability, or, time to teach. On the other hand they perceived teachers as having plenty of spare time in which to teach in the practice areas.

Teachers considered that it was primarily the practitioners who should have responsibility for teaching student nurses in the practice areas. The reason given that the practitioners only have to focus on one speciality area, whereas each link teacher has to focus on more than one, and therefore cannot be effective across all areas of practice. Under these circumstances the teachers considered that they can be more effective as a teacher / supporter of practitioners in their teaching role by ensuring that they are made aware of the students learning needs in the practice areas.

All of the practitioners considered that it was their responsibility - the practitioners of care delivery - to teach the students. However, several of the staff commented that they did not expect link teachers to teach in their area as "it did not happen". "Teachers can only give a limited time, so if the student relies on the link teacher they would not receive much support, so they (the student) come here to learn from practice nurses who gives them a breadth of experience". But on the other hand many of the practitioners identified that "often there isn't time to teach"; "not sure what to teach"; "unsure of creating teaching opportunities".

(c) Suggestions for causation factors of the theory / practice gap.

Analysis of the suggestions made by the three sets of role definers about to the possible causes of a theory / practice gap (ie. the difference between what is taught to the student nurses in the College and what is experienced by them in practice), revealed that they were classifiable into six themes which are identified in table 6.

It is in the area of linking theoretical concepts to the delivery of patient care, in which students expressed major concerns. In their opinion, there did not appear to be an identified opportunity to learn clinical skills in the training programme either, as many of the students commented "the teacher told us that we would be taught skills in the wards, but we haven't"; on the other hand, "ward staff expect us to know more clinical skills and expect them to be taught in the College".

Figure 6. Possible causes of theory / practice gap.

* Indicates where there was consensus of opinion from at least 75% (a significant number) of each role definer group as described in chapter four.

S = Students; T = Teachers; P = Practitioners.

Suggestions	S	T	P
Theoretical bias of the Common Foundation Programme	*	*	*
Apparent under emphasis of clinical skills	*		*
Institutional attitude of some practitioners (reluctance to break with old habits)	*	*	*
Lack of understanding from teachers of pressures under which practitioners work	*		*
Teachers caught in "ideal" versus "reality" trap	*		*
Practitioners unaware of educational needs of students related to different stages of training	*		*

All students were particularly concerned by the apparent lack of knowledge by the practitioners of their training needs, especially related to their varying needs at the different stages of their training. They saw this as contributing to the theory / practice gap as, in their opinion, they were either not given the "correct teaching" appropriate to their stage of training when they were senior students or were expected to "assume too much responsibility" when they were junior students.

The majority of the teachers and practitioners agreed that, although there was a theory / practice gap, it was not as wide as it had been several years ago. However, a diversity of views on the causation factors of the theory / practice gap emanated from the different specialist teacher groups these being: "the lack of opportunity for practitioners in some areas to update themselves" (Child); "some teachers have gone overboard with theory and have forgotten to relate it to practice" (Community); "institutionalised practices of practitioners, with failure to see the benefit of doing things differently because of old habits" (Learning Disability and Mental Health). With one suggestion from a practitioner being "if a gap does exist, it might not be a bad thing, for even if the nurses are taught to do things correctly, because of the shortage of staff, adaptations have to be made. The gap is not a consistent gap - it is like a hem which has become unstuck in certain areas, but the threads still hold it together".

<u>Conclusions drawn so far.</u>

The specific educational issues, as outlined on page 4/5, which are intended to be addressed by this piece of research are starting to unfold. It is clear from the students' responses that they perceived that there was a theory / practice gap ie. a difference between what is taught in the College and what they experience in the clinical setting. They viewed teachers as the teachers of theory and practitioners as the teachers of practice.

The findings indicated that there was a consensus view that, both teachers and, practitioners contributed to the theory / practice gap. The teachers, they suggested, by teaching for the ideal which, in their opinion, cannot be achieved in many of the clinical areas (the "ideal" v "reality" gap). And to many of the practitioners who have not updated themselves and were, therefore, being tied into routines and institutionalised attitudes. They identified that some of the practitioners teach new and / or old clinical practices but lacked a research base.

This situation could, in fact be perpetuated, as the research findings suggest that the nurse teachers were not prepared initially to teach both the practice, as well as the theoretical aspects of, the course. They have spent a tremendous amount of time updating themselves "theoretically", but the same amount of time has not been afforded to them by the College to up date themselves clinically.

The issue of practitioners' updating should start to resolve itself when mandatory updating for Re-Registration is finally introduced under PREP (1994). This will require each Registered Nurse to undertake five days of updating every three years in order to re-register. But what are the implications for the mandatory updating of nurse teachers? The reluctance of some of the teachers to be involved in the practice areas was attributed by the students as contributing to the theory / practice gap. The teacher teaching for the "ideal", whilst the students experience the "reality". Therefore, the implication for the nurse teachers is that they must be given time by the College to update themselves clinically.

So how can the time that teachers spend in clinical practice be best utilised? The student responses suggest that they, themselves, have varying abilities and that staff need to help them to develop more independent learning styles. Students require help to link theory to practice but

the bedside role (described in chapter three), as advocated by Castledine (1994) and McNaughtery (1992), may not be the answer for this College. Because of the large number of placement areas to which many of the teachers link there is little time available to spend in each clinical area, so a different resolution to the problem is required

(d) Resolution of the theory / practice gap.

The coding of all role definers responses were analysed using Hycner's and Burnard's methods as outlined in Chapter four which revealed the following suggestions for a resolution to the theory/ practice gap as categorised below:

- Figure 6 - those related to student support in the practice areas and their involvement within the practice areas.
- Figure 7 - those related to the practitioners preparation for their teaching / assessing role.
- Figure 8 - those related to activities which were considered as enhancing the learning environment in practice settings.
- Figure 9 - those related to the linking of theory / practice through the curriculum design and delivery of the course.

Figure 7. Student support

S = Student; T = Teacher; P = Practitioner.

Suggestions	S	T	P
Allocation of mentor	*		
Induction to clinical area	*		
Acquisition of clinical skills	*		
Be supported in clinical areas	*	*	*
Students acceptance of partnership in learning process		*	*
Students involvement in curricular activities		*	*
Students assisted to value all clinical placements		*	*
Students given assistance with appropriate written work	*	*	*

Figure 8. Practitioner preparation and support

Suggestions	S	T	P
Creation of teaching opportunities	*		*
Supported to teach/assess students	*		*
Knowledgeable of students appropriate learning needs	*		*
Updated on current philosophies of care	*		
Aware of theoretical concepts taught to student	*		*
Aware of current relevant research findings	*	*	*
Utilisation of current care planning practices	*		
Aware of student assessment requirements	*		*
Involved in student selection		*	
Knowledgeable of changes in curriculum/assessment	*	*	*
Infored of and take opportunity to update		*	

Figure 9. Enhancement of the clinical environment

Suggestions	S	T	P
Accessible/relevant reading material	*	*	
Identified learning opportunities for students	*		*
Standards set and monitored		*	*
Teachers attend ward/staff meetings			*
The placement area actively demonstrates its commitment to the education of student nurses	*	*	*

Figure 10. Curriculum design and delivery

Suggestions	S	T	P
Re-examine balance of theoretical concepts and nursing skills	*	*	*
More practical skills taught in College	*	*	*
Curriculum to reflect practice		*	
Students learning objectives to link theory to practice		*	*
Practitioners to each in College		*	*

Although the above analysis demonstrates that, there were areas of agreement amongst each

group of role definers on suggestions for a resolution to the theory/ practice gap, it also demonstrates that, there was a lack of agreement between each of the groups. This reinforces the case about the need for clarification, and consensus on a role for nurse teachers in practice settings.

(i) Student responses

The students perceived that the points they highlighted in their suggestions for a resolution of the theory / practice gap, interlinked with their views on the role of the nurse teachers in clinical practice. All students considered it important that teachers should spend regular amounts of time in clinical settings in order to be identified with the clinical area and be accepted as a part of the clinical team as opposed to being viewed as a "visitor".

Themes that emerged from the analysis of the students' questionnaires were that the role they expect teachers to perform is that of "supporter" in clinical settings, and to be "linkers of theoretical concepts to practice" as opposed to working along side them. They also expected the nurse teacher to act as a "facilitator" to practitioners assisting them to understand the students' learning needs. The teachers teaching for the "ideal" as opposed to "real" situations was a concern for students and the resolution of that "reality gap" was an issue for them. The majority of the students appeared to be supportive of Infante's (1986), Osborne's (1991) and Crotty's (1993b) model of clinical facilitator, with only 5 (4%) advocating a bedside role (Northcott 1988, McNaughtery 1992) for nurse teachers.

(ii) Teacher responses.

Only two (0.5%) of the teachers considered that it was possible to work as a "role model" to students whilst delivering "hands on care" (bedside role), whereas all teachers perceived their

role as being a liaison between the college and the clinical areas, thus acting in the capacity of a "public relations" person (an advocate for the College). All of the teachers interviewed (100%) were convinced that the role of the link teacher was a very important one, but reported that the way in which it is being done at the present time is quite unsatisfactory, resulting in role strain / overload and ambiguity, the aspects of which were identified by Goode (1960) and Infante (1986). They agreed that there needed to be role clarity.

The necessity for role clarity was emphasised by the teachers, especially in relation to the impending move into Higher Education, they felt that, unless there was a clear remit for their presence in the clinical settings, there was a danger that the role of the link teacher could become even more marginalised to the theoretical delivery of the course. For teachers there is a dichotomy in that they would wish to spend more time in clinical practice with the students, but on the other hand, they do not want to take away the teaching role from the clinical staff. It is a matter of getting the balance right. All 24 (100%) nurse teachers recorded their support for the role of a facilitator to the practitioners in their educational role.

(iii) Practitioner responses.

All respondents agreed that it was important that link teachers should help the student to apply theoretical knowledge, taught in College, to real life events, and to apply their theoretical knowledge in a practical way. Of great importance to the practitioners is the teachers working with them to achieve that aim.

They all considered that they should have the responsibility for teaching students in their own area and identified the importance of them supporting the students in clinical practice. They emphasised that students, on the other hand, need to understand their own responsibility for

learning and must acknowledge that not all learning takes place in a formalised way.

On the whole practitioners were concerned that they did not know what was going on in the College or about changes to the curriculum. They stressed the importance of having close liaison with link teachers and suggested that by working closer together they can both help the student. Emphasis was also put on the need for greater co-ordination between the practitioners and College staff so that, teachers of theory and of practice could work together to deliver an integrated curriculum. The practitioners considered that the nurse teachers have an important liaison role between the College and them, by keeping them up to date with the needs of the learner and any changes in the curriculum. Only 2 (0.5%) of the practitioners supported the notion of a bedside role for nurse teachers with the remainder concurring with Osborne's (1991) and Crotty's (1993b) proposal for a clinical liaison role, re-iterating the views expressed by Spouse (1990) of the importance of good communication networks.

(f) Proposed role of educational facilitator.

Only 9 (11%) of all of the role definers (teachers, practitioners and student nurses) advocated a bedside role for nurse teachers, with the remaining 117 (89%) recommending a role which focuses on enhancing the practice learning environment. The main focus of this role would be to strengthen the relationship between the theory and practice of nursing. This will be achieved through the nurse teachers facilitating the practitioners in the educational role so that they too can help students to link theory to practice. Osborne (1991) and Crotty's (1993b) referred to this type of role as a "clinical liaison" role. But "clinical liaison" does not reflect the emphasis on facilitating practitioners in their educational role, hence the emergence of the descriptor "educational facilitator". The responsibility of an educational facilitator being, not only to support student nurses but, to primarily to support practitioners to enhance the practice learning

environment in support of students. The main role components of an educational facilitator, emerged from the data gained from all three groups of role definers which was analysed using Hycner's (1985) and Burnard's (1991) methods as described in chapter four. These components are outlined in Appendix 6 and form the basis of a proposed standard role specification for nurse teachers in practice settings.

Reflection on my action to date.

As a manager, I was very pleased by the responses to my request for participation in the research. However I was, to a certain extent, surprised at some of the findings, especially in relation to the practitioners view on who should teach the students in clinical practice. It was surprising, that with all the increased pressures under which they work, they still see it as their responsibility and did not consider delegating this to nurse teachers. But on the other hand, I should not have been surprised because during my interviews with the practitioners, either through indirect hints or by direct statements, they made me aware of whether they considered their relationship with their nurse teacher as being satisfactory or not. The main criteria that they used for identifying effective teachers were whether they developed a good relationship with them, and whether they made time to discuss with them the students, curricular and assessment issues relating to the students. These teachers also helped the clinical staff to develop and maintain a good learning environment, and in return the practitioners reported that they could advise the teachers on changes taking place within the clinical area. Thus, they felt this type of working relationship helped the student to make sense of the "reality" of the world in which they work. Also, the students' responses demonstrated that the increased presence of the link teacher can have a beneficial effect upon the attitudes of clinical staff, especially where research based arguments have helped to change practise.

In relation to the role of the link teacher, the question is, with whom should they primarily link? The students' advocate that it should with them as the "wards don't know our needs", and the practitioners advocate that it should be with them as "we don't know the differing needs of the students". Identified within the consensus of opinions obtained from the three group of role definers is the fact the teacher could play a pivotal role in alleviating this dichotomy of view.

It was very gratifying that a consensus view on the role of the link teacher emerged which could to be tested out in practice. Although, I must admit , I was surprised that the majority of views identified the role as being an "education facilitator" as opposed to a "hands on care" role that I had anticipated would emerge.

With the introduction of Project 2000, the main emphasis of the role of the nurse teacher has been on the teaching of theory with the result that teachers have concentrated their own updating efforts into theoretical concepts. As a result of the lack of guidelines from the Statutory Body on the necessary ongoing development of nurse teachers, it is almost inevitable that the teachers have gone down this line to the detriment of their clinical updating. The teachers were of the opinion that they require guidelines from the Statutory Bodies on both the balance of theory and practice within a teachers' role. They also suggested that they required more direction and support in maintaining current and recent clinical skills.

My visits to the clinical areas were seen by the practitioners as a Public Relationship exercise, who appreciated "someone from the College coming to their area to talk to them about their area of practice". They also appreciated the opportunity to air their views on how the links between the College and their area could be strengthened through the refinement of the role of the link teacher.

Field & Drysdale (1991, p22) described action research as a systematic attempt to collect information which will help to devise strategies for solving workplace problems and overcoming skill deficiencies. They explain that almost as soon as one starts to study workplace problems, solutions begin to appear, and as action research proceeds, change should already be under way. This view was reflected in this research project, for although the questionnaires / interview schedules were designed primarily to elicit the views on the role of the teacher in clinical practice settings, interesting and valuable data on areas of curriculum design and delivery was also identified. Some of the suggestions/ ideas thrown up by the research have already been implemented.

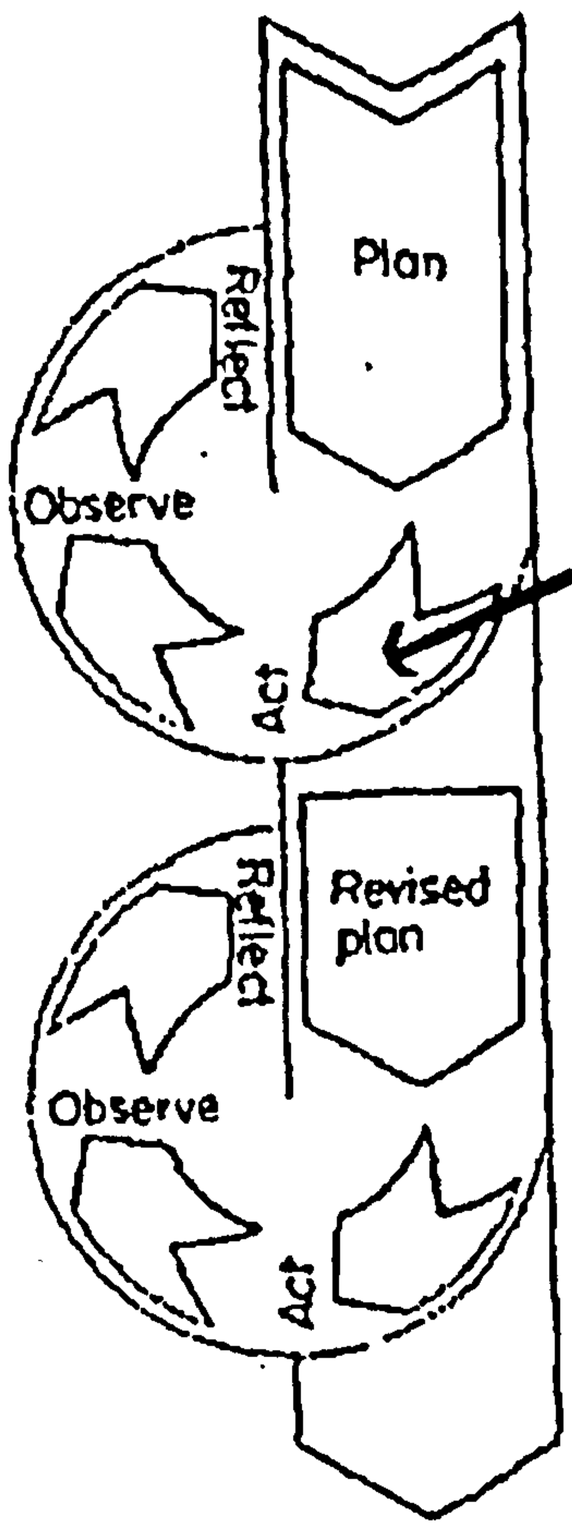
Many of these ideas had, in fact, already been elicited through other evaluation exercises but the findings helped to confirm that amendments to the curriculum were required. Issues such as student mentorship etc. have been built into the clinical audit document. The College of Health has planned and commissioned a skills laboratory in which the students now have the opportunity to practice practical and counselling skills prior to gaining experience in a placement area. As a result the students report that, they and are able to handle equipment, such as intravenous sets, whilst they are in the placement areas with greater confidence. Initial feedback from some of the teachers indicates that the opportunity to teach practical skills in the Colleges' skills laboratory has given them confidence to also teach them in the clinical settings.

CONCLUSION

This chapter has outlined the method by which a draft role specification, for the performance of nurse teachers in practice settings, had been identified by three groups of role definers. The following chapter describes the action taken to trial the emerged role in action in a range of practice settings.

CHAPTER SIX

STAGE TWO - TAKING ACTION TO CHANGE PRACTICE



2. <u>TAKE action to carry out the plan with the other people who have helped to formulate it by:</u>

(i) Negotiating to pilot the proposed role
(a) with teachers
(b) with managers of practice areas

(ii) Adjusting plans in light of changes in the College

(iii) identifying the teachers to pilot the proposed role

The precise responsibilities of the nurse teacher in practice settings in this College of Health were unclear and this was a source of anxiety for them. One of the aims of this research was to see if a standard role specification could be agreed which would detail their precise

components of the role for the performance of that role. But how does this role differ to the one being currently performed and what are the perceived advantages of the new role ?

Figure 11 Comparison of new and existing roles

Features of the new role	Features of the existing role
(i) provider of student support (ii) prepare practitioners for their teaching assessing role (iii) educates practitioners on relevancy of practice placement within the context of the whole curriculum (iv) updates practitioners on changes to curriculum / assessment procedures and of any research findings which have applicability to their practice setting (v) enhancer of the practice placement learning environment (vi) feeder of changes in the practice settings into the curriculum design and delivery Therefore the role of the nurse teacher in any practice setting is that of facilitator, enabling the student to learn and enabling the practitioners to help the learning process in the curriculum The teacher through these processes should then be able to assist in the linking of theory to practice	(i) preparation and support of clinical staff acting as mentors and assessors (ii) liaison between clinical staff and the course tutors

As outlined by Goode (1966, p314) roles are "public" in several ways: (a) fundamentally they require action. Such actions are at least partially observable by others (b) role obligations are defined, either in outline or in part, by other people - "third parties". I considered it necessary to examine whether Goode's description of components featured in either in the new or the existing roles, the comparison of which is outlined in figure 12.

Figure 12 Comparison of new and existing roles using Goode's description

(i) a standard role specification has been agreed in collaboration with three sets of role definers (**role obligation has been defined with third parties)** (ii) the role can be actioned as it has defined role components **(fundamentally require action)** (iii) the advantage of having an agreed role specification is that it allows for the setting of criteria by which performance can be judged **(partially observable by others)** and it can help to identify any staff developmental needs	(i) the role is ill defined, as outlined on pages 2/3, and was written into the course documentation by the course planners **without consultation with third parties** (ii) the role cannot be actioned as **it is not public** (it does not have identified role components) (iii) the role **cannot be actioned or be observable by others** as it does not allow for the setting of criteria by which the performance can be judged

The proposed role was trialled by a group of volunteer nurse teachers in a range of practice settings to see if it was an acceptable role and whether it might alleviate the anxiety which existed amongst nurse teachers. A further purpose was to identify any further benefits and costs arising from the performance of the role of an educational facilitator.

(a) Negotiating the way forward.

Two open meetings were held with nurse teachers to debate and clarify the draft role specification which had been validated by twenty four of their colleagues and twenty four practitioners, the process of which has been described in chapters four and five. I asked for volunteers to spend at least one day per week, for a minimum of a twelve week period, trialling the role in one of their practice areas.

The draft role specification was also used as a basis for discussion in a meeting held with NHS Trust Managers to discuss the role of an educational facilitator and how the research findings

might be taken forward in their practice areas. Written notes were taken during the meetings and Hycner's (1986) and Burnard's (1991) methods were used to codify their responses.

(i) Meetings with the teachers.

Three lunch time meetings were arranged with the teachers, which thirty people attended. The debates between us centred mostly around the presentation of my findings and the feedback received from them was mainly positive. The teachers re - iterated that it was important for them to have the "freedom to clinically update themselves in order to gain recent and relevant skills, when students were not in their link areas". This, they suggested, would give them the confidence to ask "stupid questions" and be able to remember the reality of working in clinical practice' and to be able to remember what it is like to become "physically" as opposed to "mentally" tired. But some of the teachers were adamant that clinical updating did not mean the actual "delivery of hands on care" to patients, but by becoming "au fait" with what is happening in their clinical area and keeping up to date with new practices and research relevant to their own areas.

The teachers attending the meetings agreed that their role should be as a facilitator of educational processes . They also agreed that the role should be trialled, not only to test its applicability in all practice settings, but also to test for any necessary refinements to the role description.

A few of the teachers were concerned about who they should liaise with in the practice areas, explaining that it could be difficult to speak to the same member of staff on each visit to the clinical area. Many of them considered that my analysis of their responses not only confirmed what they had believed for many years, namely that the role of the link teacher was an important role, but some of them admitted that they did not utilise all the opportunities available to enhance

the clinical links. However, despite the few apprehensions mentioned in the meetings, the teachers were enthusiastic to move forward with the research.

(ii) Meetings with the Managers.

Subsequently I made arrangements with managers of local NHS Trusts to meet and discuss with them arrangements for some of the teachers to pilot the proposed role in their areas. I used the outline role of an educational facilitator as the basis for debate. The change of relationship between the College and the NHS Trusts since the closure of hospital schools was very evident during this meeting. The managers saw the teachers as "someone from the College looking at their areas" and so were cautious as to what the link teacher would be doing in their areas; would they be acting as spies ? Would the teachers be subjective or objective about activities happening in their practice area or about the delivery of patient care ?

The managers expressed concern that some of the teachers may require clinical updating as well as piloting the new role and this could have implications for the ward dynamics. They highlighted that the whole of the culture of the organisation had changed since the NHS has been reformed. It was pointed out to them that both the College and the teachers were aware of the changes but many of them had never worked in the changed culture and it was possible that they were teaching about the changes from a theoretical perspective only. I explained that a part of the proposed role would be for teachers to become "au fait" with what is happening in practice in order to feed this back into the curriculum, the College would therefore be teaching for "reality". There would be reciprocal benefits to the practitioners as the link teacher would be assisting with their development by keeping them up to date with relevant research, this would then lead to the enhancement of their practice areas. Following this debate the managers agreed that the proposed role could be piloted in their areas.

(b) The implications of further policy changes.

During this phase of my research more policy changes occurred which had an impact upon its progress and these are outlined below.

(i) Formation of a Faculty of Health and Social Care.

The decision taken by the RHA on the integration of the College into Higher Education also involved the integration of another College of Health Studies into an existing Faculty of Health and Community Care of the University. Therefore three existing cultures would be drawn together to form one Faculty within the University with the intention to emerge with one philosophy and the development of a one curriculum which would be required to be enacted in practice across fifteen NHS Trusts. The issue of the role of the nurse teacher in practice settings therefore had to be addressed across this wider arena. An agreed role for nurse teachers had not been established by either of the other two partners and therefore I considered that if an agreement could be reached on this one area of practice it would assist in the construction of this "new culture".

The development of a new Faculty within the University had implications for control over the possible implementation of my research findings. At this period of time a new structure for the functioning of the Faculty had not been established and it was still operating as three separate organisations. As Head of Department within the College of Health I would have had the authority to implement any recommendations arising from my research. Until the structure of the Faculty was established I remained as Head of the same Department of Nursing Education on one campus site, but for the research findings to have validity they needed to be widened to include representatives from the other campuses. Although permission was given to extend the research across the other campuses, not having these other campuses within my sphere of

responsibility consequently meant that I would not be able to implement any findings, but instead only to make recommendations to the Faculty Executive Group.

Therefore until the management structure for the new Faculty was established which would identify the person with the responsibility for the deployment of nurse teachers, the research would not be able to proceed into the second spiral of initiation of any action necessary in the light of the evaluation of the role in practice.

(ii) Statutory Body Policies.

In October 1994, the ENB updated its' Regulations and Guidelines for Training in October 1994. The amendment to Section 2 regulation 8.1 (October 1994) was a major disappointment as reference to a student: staff ratio of 1:15 was removed and replaced by :-

> The number of teachers/ lecturers in post must reflect the number of programmes, students and educational activities conducted in the institution/ department, including the specific need for the continuing education/ development of staff.

The ENB had anticipated that this statement would allow for the negotiation of ratios lower than 1:15 to reflect the practice link responsibilities and for their requirement for teachers to spend at least one day per week teaching in practice settings. But there are indications, that for Colleges of Health which have already integrated into Higher Education, the reverse is the norm. Ratios have tended to have been increased to approximately 1:20 which reflect ratios only for the delivery of an academic course within Higher Education Institutions. Concern was expressed by the teaching staff within this College that similar ratios would also be a result of the process of integration into the University. Neither the RHA nor the University seem to favour a ratio of 1:15, but without such ratios it is difficult to perceive how the one day per week teaching in practice settings could be achieved. The teachers feared that without proper

recognition of their role in practice settings they would once again be experiencing "role conflict" vis a vis the demand of academia versus professional practice.

In January 1995, further amendments to the ENB's (1993) Regulations brought some glimmer of hope for the strengthening of the role by defining activities to be undertaken by nurse teachers in clinical settings, vis a vis paras :-

2.5 Liaison should include discussion with the qualified staff about the relationship between the theory and practice and the use of relevant assessment documentation.

2.3.12 If there is cause for concern during a placement, accounts of discussions held between the student, assessor and link teacher must be recorded in the assessment documentation and entered in the portfolio.

2.3.13 Where there is cause for concern the link teacher must facilitate the agreed action.

9.5.2 Education and service managers together must ensure that adequate and appropriate teaching and supervision will be available to the student.

9.5.5 In addition all those involved with the programme should be familiar with the programme structure, organisation and content.

Arriving at this opportune time the proposed role was, therefore, refined to take into account these amendments and a memorandum (Appendix 7) was sent to all teachers highlighting these changes. The memorandum requested volunteers for the piloting of the proposed role in a variety of practice settings.

<u>(c) Identifying the participants to trial the role.</u>

Although the nurse teachers were aware that it might not be possible to implement the findings immediately, they were still enthusiastic that the research should proceed onto its next stage. Initially six teachers from my own campus volunteered to participate but as a consequence of the enthusiasm shown by them the number increased to eleven, some of whom had been members of the original link teacher interest group.

Prior to the integration of the two Colleges of Health into the University, some of the teachers working within the other two campuses had attempted to identify a role for themselves in practice settings. They reported that the role which was emerging from their discussions appeared to be similar to that of an educational facilitator as identified in this piece of research. They reported that they had neither identified the actual components of the role nor had they trialled the role. Following contact with these two groups of teachers, one teacher from each of these two campuses volunteered to also pilot the proposed role in one of their practice areas. The total sample group, therefore, comprised thirteen nurse teachers from a range of nursing and sub speciality backgrounds. Therefore with representation from such a range of nursing backgrounds, the findings of the research should have much more credence of applicability.

I then contacted by, telephone, the person in charge of the thirteen link areas to which the teachers linked to ask them if they would be prepared to have the role trialled in the practice area, and to ask them if they would be prepared to be actively involved in the research. Following the explanation of what this involved, all thirteen people agreed to participate in the trial. I, therefore, contacted the clinical practitioners in their link areas who subsequently agreed to participate following explanation to them. All of the teachers were given, and all of the practitioners were sent, a copy of the role specification for reference.

As the nurse teachers were trialling the role in only one of their placement areas, I contacted the person in charge of the teachers' other placement areas to inform them of alternative telephone cover arrangements. They were informed that, if there were any queries or problems, their link teacher, a Senior Education Manager or myself would be available by telephone to give any assistance.

Conclusion

This chapter has outlined the process by which negotiations took place to identify volunteers to trial the new role in a range of placement settings. The following chapter describes the trialling of the role and the evaluation of that role in practice through the reflective recordings of thirteen nurse teachers and thirteen practitioners.

CHAPTER SEVEN

STAGE THREE - OBSERVING AND EVALUATING ACTION

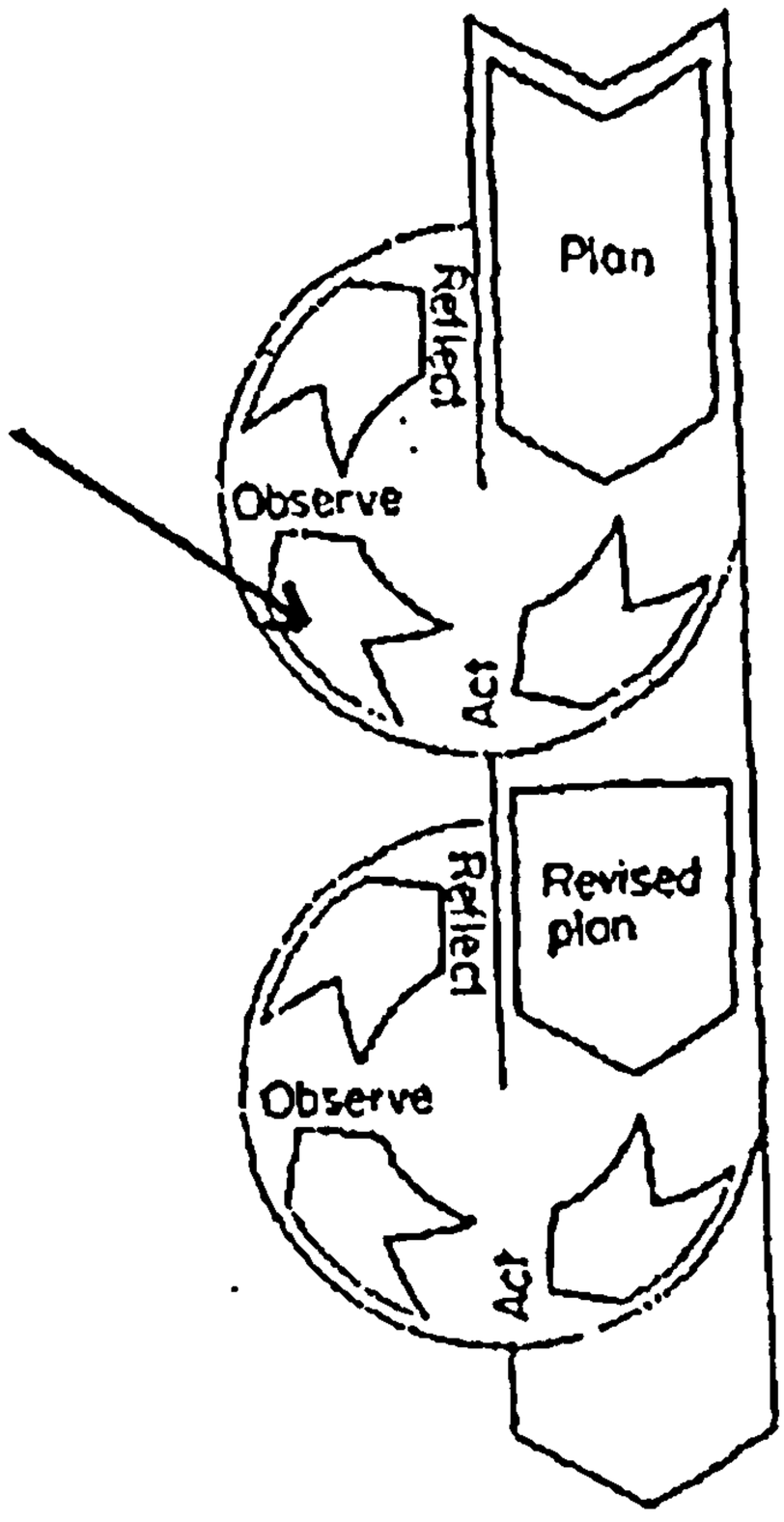
3. <u>OBSERVE the impact of your action on the situation of interest by:</u>

(i) Designing reflective diaries for use by:-
(a) volunteer teachers
(b) practitioners in respective link areas

(ii) Analysing recordings through use of Hyner's (1985) methods

(iii) validating the findings with a sample of the participants

(iv) Proposing educational facilitator protocol



<u>(a) Use of reflective diaries.</u>

In order to evaluate the role of an educational facilitator in practice settings, structured diaries (Appendix 8 & 9) were designed in which the thirteen nurse teachers and practitioners were asked to record their reflections on aspects of the defined role. The justification for the use of

reflective diaries has already been outlined in chapter four.

Conrath (1985) advised that for diaries to be accurate they must not take long to complete, and advocated the use of structured diaries for this reason. Bearing this advice in mind, the structured diaries for both the teacher and practitioner respondents contained only six areas of interest on which they were asked to reflect. The respondents were asked to post their reflections to me on a monthly basis.

Although diaries allow the researcher access to intimate situations which might otherwise be denied to him or her, they are not without their limitations, for example using this methodology I had to accept that frequency of entries into the diaries could be problematic. This proved to be the case with several of the respondents who did not either record or send in their recordings on a regular basis. Also deciphering some of the respondents hand writing and the brevity of some of their recordings were further problems which were encountered. In these situations I had to arrange follow up interviews to elicit the information that I required, but whilst proving to be time consuming they did provide the opportunity to check the recordings or to gain additional material.

(b) Analysis of the reflective diaries.

Hycner's (1985) and Burnard's (1991) methods, as outlined in chapter four, were used to analyse the contents of the reflective diaries in order to codify entries according to the structured questions presented to the respondents. An example of part of the process of codifying one nurse teacher's reflections is given overleaf:

Reflection. How has the defined role changed your working relationship with the practitioners ?

Response.

Nurse teacher's reflections	Open coding
By becoming more involved in the practice areas, my working relationships with the staff have improved dramatically.	more involved working relationship with the practitioners have improved dramatically
If any problems arise with the students on placement we are able to have honest and frank discussions.	honest and frank discussions
I have found that they (the practitioners) use me more readily for advice on their own development and most important - we have developed mutual respect.	they use me more readily for advise on their development mutual respect
I have had the opportunity to work closely with the nursing team, sharing knowledge and gaining a better understanding of clinical staffs' roles, responsibilities and pressures of work.	opportunity to work with the nursing team sharing knowledge gaining better understanding clinical staff's roles responsibilities pressure of work

EMERGED THEMES FROM THE ANALYSIS OF THE RECORDINGS.

A. How has the defined role changed the practice of nurse teachers in the practice area ?

From the teachers responses, the only speciality group which reported that the proposed role had not changed their practice were representatives from the community settings, the role which they originally reported as being appropriate for them was that of an educational facilitator. They considered it inappropriate to teach students in a patient's home because they would not be "au fait" with their care needs and they would also be an additional person to the community nurse in the patients home. They reported that the newly defined role actually "confirmed" the characteristics of the role which they were already performing. They already met regularly with

teams from the Health Centres for a "two way" exchange of ideas, but considered "it is nice to have our role confirmed".

It is interesting to note that in the fields of Learning Disability and Mental Health, the teachers who volunteered to pilot the role chose to try out the new role within teams performing group work as opposed to working in situations which required one to one interventions. This maybe because in the initial interviews they commented on the "ethical " dilemma of interfering with the interpersonal relationships which exist between the staff and clients in small group homes.

For teachers working in the other speciality areas, the increased amount of time spent by them in one clinical area, allowed some of them to be involved with practitioners in carrying out nursing interventions. This, in turn, allowed them to gain, to a certain extent, sufficient confidence to deliver "hands on care" on their own, thus giving the students the opportunity of seeing teachers working with patients and as a part of the ward team. To the teachers this increased their "credibility", not only, in the eyes of the students but also in the eyes of the practitioners, as "it provides the practical opportunities to carry out interventions, which up to now, I have only examined in theory". This statement confirms the statements made by the teachers in my preliminary interviews with them which identified that the majority of teachers "learnt" many of the current nursing theories from "text books" or from their peers after they became nurse teachers.

All of the practitioner respondents commented that the additional time spent in the practice area allowed them to become more "au fait" with and aware of the "real stresses and pressures" under which the clinical staff work and, therefore, they perceived that the teachers' expectations of a clinical area became more realistic with the result they were better able to support students.

Also that the teachers had gained a better understanding of the practice area and its staff. For those teachers who actually became involved with students and team members, it was commented that it increased the teachers "credibility". The gaining of practical skills was seen as an aid to the teaching of students and thus, many commented, "teachers are better able to address the theory/ practice gap".

The applicability of the following components of the role confirmed in this section of both sets of diaries were: student supporter and enhancer of the practice setting environment.

<u>B. How has the defined role changed the working relationship with the practitioners?</u>

It is not surprising that, as the majority of the elements of the role of an educational facilitator necessitates the teacher working more closely with practitioners, it is in this section of all diaries that the majority of their entries were made. All respondents commented on the development of **closer working relationships**, or the enhancement of existing ones, with not only practitioners, but also with students, with quotes such as "it provided me with the opportunity to get to know the practitioners better as individuals and for them to get to know me"; or "the practitioners found me approachable as opposed to someone who visits the area briefly and then leaves until the next time".

The practitioners entries concurred with the comments made by the teachers which outlined the advantages of the development of closer working relationships between them. With practitioners having "an opportunity to get to know **our teacher** assists with the breaking down of barriers", and "gives the teacher a better understanding of the clinical area and how we can work together to support students".

Establishing closer working relationships was identified as a way of breaking down the hierarchical barriers which exist in nursing. With comments such as **"sharing of knowledge, closer working relationships** are developed with the College and practitioners can see teachers as people, it removes the hierarchical boundary that is so entrenched in nursing", and "it gives a chance for students to see teachers using their clinical expertise and are then able to learn from this. It breaks down barriers between teacher/ student and College/ practice area".

The practitioners writing that the changed relationship has "given them the confidence to discuss openly with the teachers the student's needs and to ask about what they are expected to achieve in their area, before I didn't like to ask", also "we have more opportunities to discuss what is expected of us (the practitioners) in terms of mentor / assessor role", but "also to know that we can rely on the teacher for support when a problem with a student arises is of great comfort to us".

It was confirmed that the time spent by each teacher in one clinical area increased the opportunity for the **exchange of ideas and information relevant to educational matters** and to "maximise all learning opportunities". Entries in the teachers diaries indicated that some of them had initial fears about "being exposed" in the clinical area in that they had anticipated that the practitioners would have expected them to be a "font of all knowledge", but these fears were soon allayed because of the development of a closer working relationship and mutual respect had, in fact, "allowed staff to realise that, although I am not a font of all knowledge, I can assist them in finding any relevant information".

The teachers evaluated that the development of closer working relationship with the practitioners had provided them with the opportunity to update them on appropriate aspects of the student

nurses programme, and to discuss practice and theory issues. It also provided the opportunity to "value each others' role ie. practitioners offer the environment in which to practice nursing skills, the educationalist offers access to research material / literature to inform and keep practitioners up to date". Teachers themselves acknowledged the opportunity "to draw on the experiences of the expert practitioners who have been working in that area for many years".

The change in the working relationship, and the perceived approachability of the teachers, appears to have encouraged practitioners to be more forth coming in approaching teachers for advice on their **own developmental and professional updating needs.** The ultimate benefit being quoted as, "teachers providing an additional resource for updating of practitioners, source of advice on my own personal development helps me to support students more ably".

The practitioners confirmed the teachers perception that they had gained confidence to approach them about their own professional updating needs which they considered as "allowing the teachers to gain additional knowledge about patient care and therefore can support students more effectively" and the "closer links generally with the ward staff and other members of the multi disciplinary teams helps them to relate theoretical concepts to the delivery of care". Similarly, they reported that the changed working relationship allowed them the opportunity "to use the teacher as a resource for their own updating which in turn is of benefit to students and patients".

Without exception, teachers from all speciality backgrounds commented positively about the benefits that resulted not only to themselves, but also for practitioners and students, from working closer with practitioners and summed up as "by becoming more involved with the clinical area, my working relationship with the staff has improved dramatically. If any problems arise with students on a placement we are able to have honest and frank discussions. I have

found that they use me more readily for advice on their own development and, most important, we have developed mutual respect".

The applicability of the following components of the role confirmed in this section of the diaries were: student supporter; practitioner facilitator and enhancer of the practice setting environment.

C. How has the defined role affected the day to day work of the nurse teacher?

The teachers perceived longer term benefits arising from the change in the way in which they work in a clinical area with quotes such as "in the past we were often viewed as a passing stranger even if I had spent several hours on the ward. But now, because there is a structure to the role which is understood by everybody, I feel that I am used as an "agent of change"; also "some of the staff have felt disempowered to make change. One or two situations occurred whilst I was in the clinical area and I was able to give advice on how to improve the management of such situations. This advice was accepted and implemented, this would not have happened before, I now feel they are confident that I am not here just to sit in judgement of them, which can happen when someone from the College just visits the clinical area". The practitioners acceptance of advice on relevant research material was also recorded by several of the teachers in their diaries, who perceived that the delivery of care and evaluation of interventions as being much more research based.

The longer term benefits perceived by the teachers arising from the change in the way in which they work in the clinical areas was concurred by the practitioners entries' in their diaries. Reported improvement in the relevance of aspects of the delivery of care taught by nurse teachers were noted in many of the entries, "it has provided the opportunity to improve her general knowledge on medical conditions and so she can relate more up to date knowledge to

students" and "closer contact with the patients made her aware of their specific needs and can now relate them to the student".

Most practitioners perceived that teachers were more able to relate theoretical concepts to practice relevant to their areas in that "a teacher who experiences first hand what is happening in a clinical area can relate personal experience to students and so their teaching is from an integrated theory and practice approach and not just from a theoretical stance"; and "it provides the opportunity for the teacher to discover their ability to put theory into practice because of being able to experience the delivery of hands on care once again with patients".

The practitioners commented that in some of the practice areas the teacher was perceived as being more of a **team member** which the practitioners considered as a great advantage in that "as opposed to appearing aloof, I felt the teacher became a part of the ward team, which creates a better learning environment for the allocated student; the student can see team work in action"; and "being part of a clinical team has helped **our** teacher to renew his knowledge in that things don't always go as planned even if all the preparation has been done and, therefore, he is much more realistic in his teaching of the students".

The perceived improvement in teachers' confidence to deliver some "hands on care" and to "work with students" was commented on as teachers being more able to work as a "role model" to students and also of being more confident to admit to their limitations and to ask for help when required.

The teachers' evaluations also highlighted that they considered they "can listen more effectively to students who are describing their patients and are more able to give relevant advice" also "by

becoming more aware of the learning needs and specific outcomes for students.

The applicability of the following components of the role were therefore confirmed in this section of the diaries: student supporter; practitioner facilitator; enhancer of the practice setting environment and enhancing curriculum design and delivery.

D How has the defined role

(i) improved the practice of nurse teachers ?

The teachers perceived an increase in their confidence to work in a different way in the clinical area which was recorded by statements such as "I feel more confident in my ability to apply principles in practice, especially my psychomotor skills and manual dexterity with a number of nursing procedures", and "in developing an understanding of how services can be organised, referrals made, care packages planned, implemented and evaluated has given me the confidence to practice, and what is more important, to teach the relevant procedures to the students".

An increase in the relevance of their teaching due to their increased involvement in the practice areas was highlighted in this section of their diaries when writing "increased my understanding of the skills required of, and demonstrated by, the practitioner in the field" and "working with patients provides the opportunity to enhance my therapeutic nursing skills with elderly clients and their family and use them to teach the students".

The indications are that the improvement in the teachers' confidence is allowing them, where appropriate, to act as a "clinical role model" to students. One teachers confidence appears to be coming from "being aware of my own strengths as opposed to concentrating on my weaknesses"

The applicability of the following components of the role confirmed in this section of the diaries were: student supporter and practitioner facilitator.

(ii) assisted practitioners to acquire a better understanding of meeting the needs of student nurses ?

Without exception, all practitioners recorded that they had a greater understanding of the practice experience outcomes which were required to be demonstrated by the students. As the main area of emphasis of the role of an **educational facilitator** is in the creation of an improved practice learning environment through a greater understanding shown by the practitioners of the learning needs of students, the entries in the diaries have indicated that the role of an educational facilitator has, in fact, applicability in all practice settings. Statements from practitioners confirm these observations recording statements such as "I can assist students with greater confidence through times of difficulty and I am more confident how to teach and support students"; and "gaining support from the teachers has given me confidence in supporting students and meeting their needs"; and "the increased presence of the teacher has promoted within the ward team the educational skills and knowledge to learn so we are better able to meet the needs of the students".

(iii) assisted practitioners to link theory to practice ?

The support given by the teachers was highlighted by the practitioners as assisting them to link theory to practice in "the theoretical knowledge the teachers brought to the staff team has now assisted them to be more able to support students to link theory to practice"; also "having discussions with the teacher about the students learning needs and what they are taught in the College helps us to link theory to practice". Assistance was also identified by "the teacher acting as a source of reference eg. research relevant to our clinical area has helped the teaching

of the practitioners to be more relevant in linking theory to practice".

Entries in the practitioners diaries have demonstrated that the opportunity for them to discuss current issues in student training programmes assists them to link theory to practice and that they consider themselves as being more able to support students whilst in their areas.

E. The teachers reflections on performing the defined role

The teachers perceptions on performing the proposed role were organised into the following three categories:

(i) Perceived advantages to the teachers.

The teachers entries indicated that their own personal motivation is linked to their own professional development and ultimately to the enhancement of the curriculum, with teachers writing "it made me realise that so much could be achieved by working with the practitioners if time allowed, which would benefit, not only students and staff but also, patients". There are several key issues which appear to have been learnt through teachers' regular contact with the placement areas, one being that many of the teachers recorded that there is an increased level in their personal clinical competence, which in their opinion has tremendous "spin offs" in the classroom as students are more interested if their credibility is evident".

The learning of practice issues relevant to the curriculum was also highlighted in recordings such as "the approach to manual handing in the practice placement has given me useful ideas for the manual handling programme in the College - seeing a problem solving approach in practice was extremely useful".

Another key issue expressed was of the value of the opportunity for them to put theory into

practice" and of "being able to help practitioners and students make the links". The teachers also recorded that they had been stimulated to re-shape their teaching material so that it has more relevance to practice, with one teacher recording his "replanning of course content as a result".

The feeling of personal satisfaction in regaining some nursing skills was an area of discussion in many of the diaries which was considered as increasing their confidence to teach students in the clinical situation, for example one teacher noted: "I was not aware initially of the panic or apprehension I had about going into the area, but now I have pride which is centred on the acquisition / relearning of nursing skills which I can use to the benefit of my teaching".

The entries have indicated that there is a two way benefit to the delivery of the curriculum from teachers being in practice settings on a regular basis, the teachers are to feed information into the clinical areas and any relevant information gained by them can be fed into the curriculum thereby creating a closer link between theory and practice.

Many of the entries in the teachers diaries noted the opportunity that was available to them to update their clinical knowledge/skills. These opportunities varied according to the teachers speciality background and the appropriateness of the updating activity, for example teachers working in wards in acute hospital settings took the opportunity to work with patients to deliver "hands on" care, whereas teachers working in Community, Learning Disability or Mental Health settings tended to become involved in group work activities.

(ii) Perceived advantages to the practitioners.

The teachers' reflections indicated they perceive that they have been able to identify those practitioners who are eager to teach students and therefore, they have been able to help them

structure their teaching and to help build up their confidence to do so "by working as a team member, it is possible to role model different teaching opportunities to practitioners by working with the students for a shift. It is only regular clinical contact involving patient care which enables the teacher to achieve this competence".

The teachers recorded that practitioners are more generally aware of personal and professional development opportunities and they reiterated the importance of acting as a resource person to practitioners.

One teacher reflected that a change in the name of their role in practice settings from "link teacher" to "educational facilitator" had led to a change in the attitude of clinical practitioners towards them. "The name of "link teacher" appears to devalue our role in clinical settings, it doesn't scream out at you that it is an educational role and it certainly doesn't have the same clout as the old clinical teacher role. The ward sister used to listen to us when we made suggestions but since then we have had to work very hard at it. The geographical distance from the hospital has also made a difference and we have had to make a concerted effort to build up a relationship with the practitioners. The role of an educational facilitator, with clearly defined parameters, has changed all of that, practitioners are much more willing to listen to us and to make the necessary changes in their practice area. Also the practitioners are much more motivated to make changes when we work with them".

(iii) Perceived advantages to student nurses.

The teachers' perceived that good practitioner/ teacher relationships have led to a more honest approach between teachers and practitioners to improving the learning environment which increases the level of student satisfaction / learning. With all teachers reflecting expressions such

as "Student motivation and interest is enhanced by the presence of the teacher in the practice setting". However, these perceptions would need to be confirmed by student nurse themselves in the second cycle of the research.

F. What were the perceived disadvantages of the defined role ?

Some of the teachers identified that initially apprehension was shown by some of the practitioners in that some of them had made comments about them being "a spy from the College". Three teachers actually recorded that, initially, they were seen by the practitioners as an "additional pair of hands" and they "now understand how the student feels in this situation". In both of these circumstances these myths were dispelled once the barriers were broken down, but it is a lesson to be learnt for the future when I hope to extend the working of the role into additional practice areas. More time must be spent in clarifying the role / purpose of nurse teachers presence in their practice area.

The time element was a factor on which the majority of the teachers commented because there was no allowance made in their academic teaching commitment to trial the role. They typically wrote statements such as "very, very difficult to get time to be out there"; and "it was difficult to find the time and I found myself having to cancel two pre-arranged shifts due to work commitments at the College" and "divided loyalties between teaching demands in the College and the desire to expand clinical exposure".

The teachers identified that, in some of the practice areas, there was high staff turnover and so they identified that "it is a constant battle to update staff and so need to be there regularly. A major disadvantage identified by the teachers was shown in their concern as to what was happening in their other link areas whilst they were concentrating on just one of them. They

identified that, in order to be able to support all of their areas in future, time must be allocated to them to visit the practice areas.

Fifty per cent of the practitioners wrote that they could not think of any disadvantage to the role because "in essence it is an excellent concept". However, the remaining fifty per cent commented on the time element, whilst obviously they appreciated the increased amount of time spent by the teachers in their areas, they indicated that they would appreciate it if even more time could be spent with them. They identified that the time available can be inflexible vis a vis College commitments versus placement commitment; and "the teacher needs more time as she has to fit in academic and clinical work".

These findings confirm the suggestions of Clifford (1993), Fawcett & McQueen (1993) and Windsor (1990) in that the liaison role is time consuming and therefore time must be made available for the performance of this role.

The role was trialled without the proper time allocated for its performance and therefore confirms the necessity of the ENB's (1993, section 2) recommendation that teachers should spend at least one day per week in practice settings, and in order to do that each teacher should be counted as 0.8 FTE. The research findings have demonstrated that unless there is clearly identified time for teachers to spend in practice settings they will continue to experience "role stress" and "role overload".

These findings have implications for "resource allocation" when determining the assignment of duties and determination of academic work loads within the Faculty, and, therefore recommendations will be made, in chapter eight, to the Faculty Executive Group in this respect.

Validating the findings.

Following my analysis of the contents of the diaries, and my write up of the results, I held a meeting with representatives from the teacher respondents and a separate meeting with representatives of the practitioner respondents. For validation purposes, the perceptions arising from each of the respondent groups were shared and discussed with the opposite group of respondents. As with the analysis of the material derived from the semi-structured interview schedules I discussed, separately with representatives from the participant teachers and practitioners, the emerging themes for authenticity. I wanted them to clarify and confirm for me whether the data was there to support the emerging themes or whether they emerged because I wanted them to emerge.

Both the teachers and practitioners confirmed that the role components identified for an educational facilitator had been fulfilled, and the advantages of performing such a role were highlighted within the text.

The teachers were able to perform the role which was envisaged for them in the Project 2000 proposals (1985, p12), in that they were involved in the whole curriculum - enabling the learning of theory and the application of that theory in practice. Therefore, the teachers were teaching in the wider context of helping practitioners to develop and enhance an educational environment in which students practice. The teachers facilitated practitioners so that they were better equipped to support and assess students. The teachers, themselves, were more able to keep up to date with what was happening in practice and to use this information effectively to change their teaching and the appropriate parts of the curriculum.

The successful implementation of the role was achieved through increased channels of

communication between teachers and practitioners, and a better understanding of each others' role and how best they can support each other to support student nurses. Improved communication channels were developed through teachers and practitioners sitting down regularly to discuss educational issues, outlined in the role specification, as opposed to "casual chats". This demonstrates the benefit of having a 'structure' to the role of which all role definers are aware. The key word throughout the analysis appears to be "confidence", both teachers and practitioners reporting that they felt more confident to support students.

The findings of this research indicate that the minimal acceptable criteria for the role of an educational facilitator have been identified and performed successfully, without any reported conflict, within all areas of practice within this College. But in the Adult Branch and Child Branch practice areas some of the teachers were able to work beyond this minimal criteria to deliver "hands on care".

The teachers felt comfortable in the performance of the role of an educational facilitator as they were "teaching" in both the classroom situation as well as the practice settings. Also it allowed all of the teachers participating in the research, to fulfil the UKCC's (1985) expectation in that they were "enabling the learning of theory and the application of that theory in practice". It also allowed them to meet with the ENB's requirements (1993, section 2) in that the teachers are enabled to remain engaged in practice, and should be involved in teaching in practice settings for the equivalent of one day per week.

However there were reports of conflict of loyalty between the demands of academia and practice ie. commitment to the College and the desire to support students in practice settings. Therefore in order to remove this felt conflict of loyalty and for teachers to be able to work, according

to the UKCC's expectations and the ENB's requirement, it is recommended to the Faculty of Health and Social Care that the liaison role is a part of the assignment of duties for nurse teachers.

The overall benefit demonstrated by the performance of the defined role was summarised by one teacher when writing "In short I feel that there is justification to spend one working day each week working with the practitioners in the practice settings. I believe the benefits to the practice area, nurse teachers themselves and to students will ensure quality education".

Taking the research findings forward.

At this stage of my research, the structure of the Faculty has still not been established, and therefore I am not in a position to implement the proposed role across the whole of the Faculty. The nurse teachers who have trialled the role are committed to the continuation of the performance of that role and therefore, a recommendation will be made to the Faculty Executive Group that the role be further trialled across the whole of the Faculty.

There are debates within the Faculty on the precise activity of all teachers in practice settings within the available resources. These debates commenced in May 1995 when the University's tender document stated:

> "College based staff would continue to visit placements to ensure effective audit, liaison and co-ordination. This would not require all students to be visited on each placement by a College teacher" and that "they would wish to explore the variants of the (link teacher) model" (UWE, 1995, p55).

The "model" which has emerged from this piece of research, and which has been evaluated as effective in practice, is one which places emphasis on "effective audit, liaison and co-ordination" and therefore is consistent with the philosophy outlined within the University's tender document.

The role has been evaluated as effective in assisting practitioners to perform their educational role in support of student nurses. However, it has been demonstrated that the effectiveness of the performance of the role is dependent upon the time allocated to nurse teachers to perform it.

The findings of this piece of research should assist the Faculty in its' "exploration" of the (link teacher) role and be able to constructively contribute to the debates.

I intend to take the research forward by recommending to the Faculty Executive Group the following protocol for the performance of the role of an educational facilitator (as identified in APPENDIX 6) plus the time necessary to carry out the role as a solution to the problem of identifying a role for nurse teachers in practice settings. The protocol will make "public" (Goode 1966, p314) , not only to the role definers but also to the purchasers of the Colleges' courses, the quality assurance mechanisms which are in place to enhance the linking of theory to practice. It will also demonstrate the College's commitment to the support and maintenance of an educational environment in which student nurses are enabled to achieve their practice learning outcomes and become competent practitioners.

<u>Proposed educational facilitator protocol.</u>

As a provider of quality education, the Faculty aims to promote and maintain a positive learning environment in practice settings, in order to enable students on programmes, to take full advantage of the wide learning opportunities and experiences available to them, in placement areas. This is achieved through the continuous liaison and the maintenance of effective communications between practitioners and teachers. The practitioners working within the placement area are the major influence upon the quality of the learning environment. It is within this context that supporting the ongoing professional and educational development of these practitioners is seen as the primary process by which the educational facilitators will achieve their goal.

The primary purpose of the educational facilitator role is to support the development,

maintenance and improvement of an appropriate learning environment for students within the placement area(s) to which the teacher links, and to contribute to the identification of the professional needs of staff within the placement area.

The educational facilitator role is integral to the Learning Environment Audit process and the ongoing practice area monitoring, this produces a link between the two elements of the ongoing support and development for placement areas. Also for the audit of the learning environment to ensure the area can be supported in maintaining the required standards to remain a placement area for students. The time spent in practice areas would also allow for the supervision and support of students, especially at times of difficulty, and for teachers to maintain and develop their professional knowledge founded on contemporary practice.

Proposed time element.

It is recommended that the necessary working conditions be made available to teachers and therefore, when determining the assignment of teachers' duties and determination of their academic work loads, that time be allocated to this role. For full time teaching staff, it is recommended a minimum of 7.5 hours per week be allocated for the purpose of the educational facilitator role, and for part time staff an equivalent minimum amount proportional to the number of hours worked.

CONCLUSION.

In this chapter I have described the process through which the role of an educational facilitator was evaluated in practice through the use of reflective accounts written by volunteer teachers and practitioners. The role was performed in a range of practice settings and evaluated as acceptable and workable, arising from which a draft protocol for the performance of that role was developed. In the following chapter I will be reflecting on the process and outcomes by which the role was defined and agreed. Also I will make any further recommendations, as appropriate, to the relevant committees/ organisations.

CHAPTER EIGHT

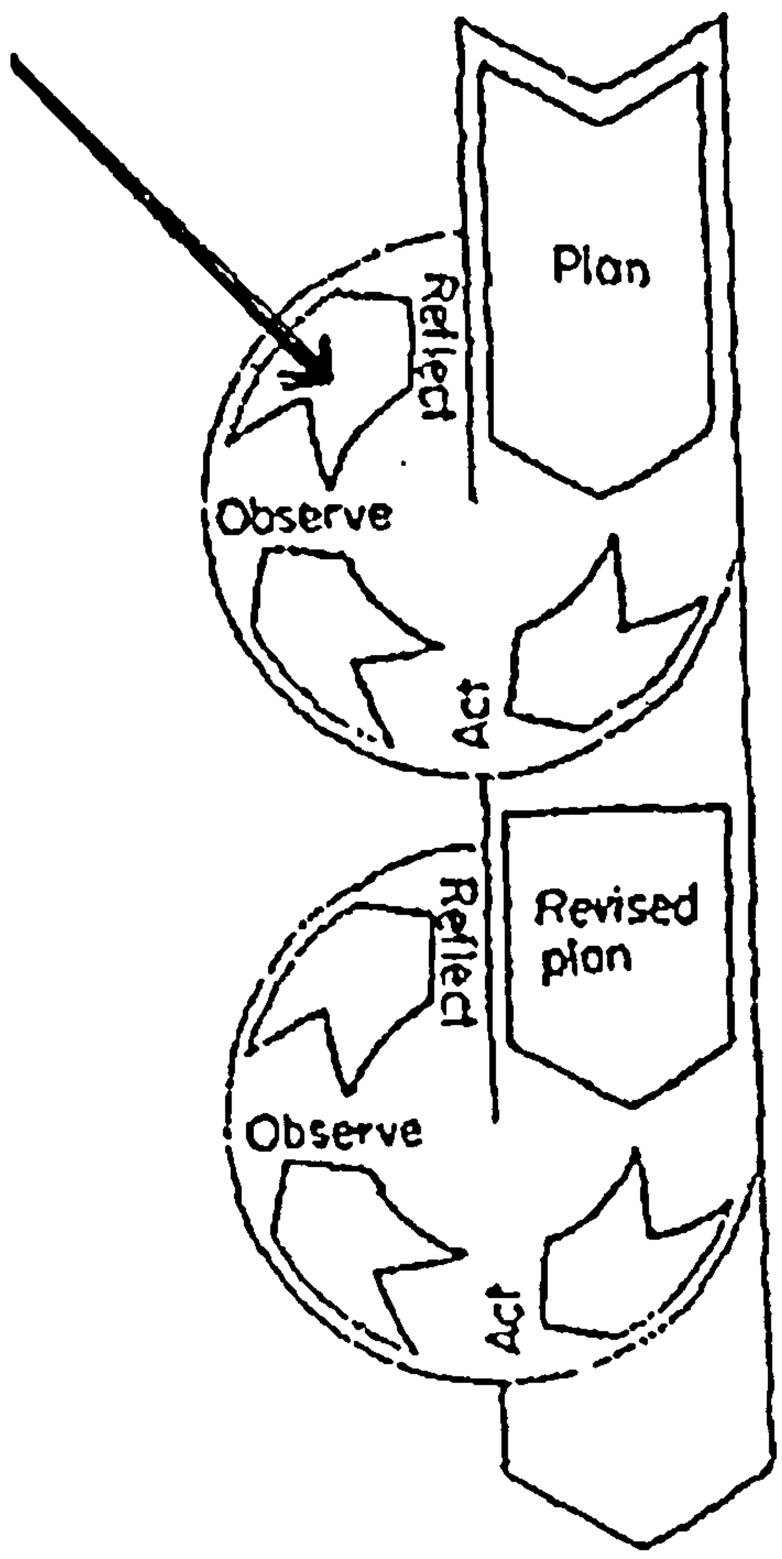
STAGE FOUR - REFLECTING ON THE ACTION

4. <u>REFLECT on the outcomes as a way of deciding what action to take by</u>:

(i) Evaluating the process

(ii) Evaluating the outcome

(iii) Making recommendations arising from the research



The aim of my study was to conceptualise a role for nurse teachers in clinical practice in the context of the introduction of social and educational policies which impinge upon and create demands for these teachers. An action research approach was used to investigate the role of the nurse teacher in practice settings. The general idea for the research originated from three sources of concern over the performance of that role. These concerns were expressed by local

NHS Trust Managers, student nurses and nurse teachers themselves. These concerns prompted me to set and collectively agree with the nurse teachers the intended aims for the research.

Stage one involved clarifying with the nurse teachers their concerns in relation to the lack of a defined role in practice settings and involving them in collaborative work to identify the areas which required to be explored in order to define a role for them. Through the collection and analysis of data obtained from student nurse, practitioners and nurse teachers it was established that there was a perceived theory/ practice gap in the curriculum delivered by this College of Health.

Although, interestingly none of the role definers directly attributed the theory / practice gap to the supervisory role of nurse teachers in practice settings, the resolution suggested by them for the closing of this gap, in fact, indicated otherwise. All role definers suggested that nurse teachers have an important role to play in assisting student nurses and practitioners to make the link between theory and practice. The proposed role for nurse teachers in practice which was identified was that of an educational facilitator, whose primary responsibility is to support the development, maintenance and improvement of an appropriate learning environment for students within the placement area (s) to which the teacher links and to assist with the linking of theory to practice.

Stage two involved taking action to change the practice of nurse teachers which commenced by seeking volunteers to trial the new role in one of their practice areas. Then negotiating with Managers from local NHS Trusts for the nurse teachers to trial the role in their practice areas.

In stage three, volunteer teachers trialled the role in one of their practice settings in agreement

with the person in charge of the practice placement. These practitioners also agreed to be actively involved in the research. The teachers and practitioners were asked to record their reflections on the effectiveness of different aspects of the new educational facilitator role. The analysis of their recordings in their diaries confirmed that the role of an educational facilitator was both appropriate and effective in all practice settings.

Although a suggested role for nurse teachers practice settings in this College of Health (Faculty of Health and Social Care) has emerged, ongoing evaluation and refinement of the role is required. With an action research approach the work is ongoing and the task is not finished at the end of the first cycle. Action research is a dynamic process (Kemmis & McTaggart, 1988, p12) and therefore it is important to recognise that the general plan and the successive action steps will be modified in the light of experience. Therefore, it is important for me to reflect upon, both the product and the process of cycle one.

<u>The product of the action research process.</u>

Views on a role for nurse teachers in practice settings were sought from a sample group of nurse teachers; a sample group of practitioners with whom they link in the practice settings and student representatives who have their practical experience in the placement settings. Only 9 (11%) of all of the role definers advocated a bedside role for nurse teachers, with the remaining 117 (89%) recommending a role which focuses on enhancing the practice learning environment. The main focus of this role would be to strengthen the relationship between theory and practice. The main role components of an educational facilitator emerged from the data gained from all three groups of role definers. The data which was analysed using Hycner's (1985) and Burnard's (1991) methods, as described in chapter four, and the role components are detailed on the next page:

(i) ROLE COMPONENTS OF AN EDUCATIONAL FACILITATOR

Although the nurse teacher will retain the responsibility for student support, the main emphasis of the role in practice settings is to strengthen the relationship between theory and practice. This will be achieved through the facilitation of practitioners in their educational role and by enhancing the practice learning environment in support of student nurses.

Student supporter.

(i) act as a supporter/ teacher
(ii) act as a role model by demonstrating appropriate attitudes and professionalism
(iii) ensure that each student is aware of what is expected of them
(iv) assist students to value each practice placement
(v) assist students to link theory to practice
(vi) act as a clinical teacher (as appropriate)
(vii) give guidance on written assignments relevant to practice areas

Practitioner facilitator.

(i) communicate the nature and level of students' education and training requirements
(ii) assist practitioners to create teaching opportunities
(iii) update practitioners on changes to the curriculum/ assessment
(iv) assist with student assessment
(v) update practitioners on research relevant to their area
(vi) give guidance on the support of students in their practice area
(vii) advise on updating opportunities
(viii) encourage practitioners to participate in teaching activities in the College
(ix) encourage use of reflective practice
(x) give assistance with problem students

Enhancer of the practice setting environment.

(i) be conversant with the activities in the area
(ii) ascertain the learning opportunities available to the students and jointly agree with practitioners appropriate learning outcomes
(iii) act in a quality assurance role by preparing clinical areas for audit, undertaking the audit and monitoring the implementation of the recommendations arising from the audit

Enhancing curriculum design and delivery.

(i) feed back information into the College on any changes in the practice areas which affects the delivery of the curriculum

It is envisaged that by performing the proposed role the link teacher would be **teaching** in the wider context by helping practitioners to develop an educational environment. Thus the practitioners would be better equipped to support students. The link teachers would be **keeping up to date with what is happening in practice.** The successful implementation of any new agreed role would be through increased channels of communication between the link teacher and the practitioners so that they have a better understanding of each others' work and how best they can support each other.

As outlined, in chapter one, it is important to have quality assurance/ control mechanisms in position in order to ensure that the education and training students' receive meets the requirements of the College/ Faculty and of the local NHS Trusts and, more importantly, that the education and training produces competent practitioners. This, as indicated by the findings of the research, can be achieved by nurse teachers acting in the role of an educational facilitator enhancing the learning environment in support of student nurses.

This facilitator role does not necessarily involve the teachers being "clinical experts" but is one whereby, teachers concentrate mainly on promoting a student centred approach to education in the practice settings. Therefore the teachers are acting as "a teacher" in clinical practice as well as in the College/ Faculty setting thus reducing the possibility of role conflict, arising from the expectation that nurse teachers should have the dual role of being "a nurse" as well as "a teacher".

Advantages and potential costs of the educational facilitator role

The research findings demonstrated that the continued presence and support of the nurse teacher can increase the practitioners' motivation to provide a favourable learning environment. Kirkwood's (1979) findings about the supportive nature of nurse teachers to the clinical staff "who are struggling to control the non - teaching aspects of their role whilst attempting to implement a teaching role", are just as relevant today as they were then. There are many changes occurring in the National Health Service which, Hydes (1995) identified, have direct affect upon the practitioners who may not be able to cope with the conflicting demands of caring for patients and teaching and assessing student nurses and health care assistants. By fulfilling the role of an educational facilitator, the teachers would not only be supporting the practitioners

in their teaching role but, would also be involved in the integration of theory and practice throughout the whole of the curriculum, as envisaged by the UKCC (1986), by "enabling the learning of theory and the application of that theory in practice". Marson (1982) questioned whether it is possible to create an atmosphere conducive to learning in a clinical environment orientated to giving care. I would suggest the findings of this piece of research demonstrate that, with the support of a nurse teacher whose role it is to act as an educational facilitator, this in fact is possible.

Owens (1993) identified in her research that nurse teachers remained rigidly bound to the confines of the course curriculum, but if teachers "get out there" it affects the curriculum in that they are able to respond to identified changes in the practice area and are able to adapt the curriculum and their teaching accordingly. The findings from this research concur with Owen's (1993) view, in that it has been demonstrated in this College of Health, the increased presence of the teachers in practice settings does, in fact, bring about necessary and appropriate changes to the curriculum which are relevant to both the practice setting and to the theoretical delivery of the course.

Slevin (1992) highlighted the importance of nurse teachers demonstrating competence in four areas, that of teaching, knowledge, clinical and academic credibility. But what does credibly mean? Burnard (1992) has queried how it is possible for teachers to be credible in all of the areas expected of them ie. teaching, practice, research and writing for publication. The question of the teachers credibility in practice settings also needs to be asked, does it mean "hands on care" in each of the practice areas to which they link and if this is the case - how can this be possible? The research has shown that teachers have a great difficulty in fulfilling a clinical role. However, Fawcett & McQueen (1993) suggested that clinical credibility should be viewed

more in terms of preparing, supporting and guiding practitioners. This is an important notion for this Faculty to debate in relation to nurse teachers acting in the role of an educational facilitator, as further change is about to take place in the form of a Faculty wide modular programme which is to implemented this Autumn. Ultimately nurse teachers will have an important role to play in this process. The practitioners in all practice areas will need to know the relevance of the new curriculum to their practice area in order to be adequately prepared to support and assess the students. As an identified component of the role of an educational facilitator is to "update practitioners on changes to the curriculum / assessment process, I would suggest that the linking of theory to practice will still be achievable.

In addition, the practice areas in which the curriculum is to be enacted may be different to those currently used and therefore there is no guarantee that the teachers would possess the appropriate clinical skills to deliver "hands on care" in those new areas. But acting as an educational facilitator will allow the teachers, not only to meet the diverse demands which the new modular scheme will place on them but also, to ensure that theory is related to practice.

The role specification, whilst outlining a "minimum" performance criteria, is not intended to act as a "straight jacket". The role has the flexibility to allow for individual teacher interpretation for the criteria on "student support" in relation to the teaching aspect of the role.

The UKCC (1981) proposed that the formulation of links between Colleges of Nursing and Higher Education would allow for the creation of a bridge, whereby there could be discussion / co operation on professional education between the Health Service and Institutions of Further/ Higher Education for the delivery of educational programmes which meet the needs of patients / clients. A supplementary paper produced by the University into which we have integrated,

(UWE, 1995 p5) acknowledged that the proper integration of academic and clinical learning for students requires a well planned interaction between clinical and university staff and training for clinical staff. The suggested role for nurse teachers, who would be working across these boundaries, would allow for the achievement of the university's stated aims. And, as the ultimate aim of the education and training of nurses is to enable them to meet the needs of patients/ clients, the aspirations of the UKCC (1981) would also be achieved. This an opportunity for the Faculty to make the role of nurse teachers in practice settings known to practitioners and students alike. I suggest that if nurses were to adopt the educational facilitator role this would perhaps fulfil other needs that have been identified by both the practitioners and students (eg enabling nurse teachers to develop a better understanding of the reality of ward work and a closer working relationship with practitioners; providing support for mentors and assessors). Taken in combination, all these factors would mean that nurse teachers would become far more part of a practice based team than they appear to be now. The role components, as identified by the role definers, are acceptable to the teachers, acting in a supportive role does not appear to present them with "role conflict". It does, however, present them with a conflict of loyalty between their academic commitments and their desire to keep their practice links. This, therefore, raises a question about the resources, particularly time, required for the performance of the role. Effective practice setting liaison in itself demands commitment, time and skills and this can result in positive outcomes as theory is related to practice, the practitioners are kept involved and updated in the learning needs of students and nurse teachers perceive that they are still significantly, if indirectly, influencing the quality of practice place teaching.

The role of the nurse teacher as an educational facilitator is a complex and demanding one. It will require a real commitment of time and energy within the practice settings and the

recognition that, as practice placement staff change, the liaison role will be on - going . To be fully effective, it could be argued that the teacher would have to spend a significant amount of time within the practice placement context to be aware of the range and quality of learning opportunities available to the students. In order to carry out this role effectively, it is recommended that practice contact time of 7.5 hours (the equivalent of one day) per week, be included in the total student contact hours. Whilst appearing to have only cost implications to the Faculty I believe, as I have outlined in the next section, that there are many benefits to be gained from nurse teachers working in practice settings.

(iii) My reflections on the costs and benefits of having a defined role for nurse teachers in placement settings to the organisation.

As I am no longer in a position to take my research findings forward, it is important that I reflect upon my perceptions of how the "defined" role can contribute to the evolution of the Faculty's core mission. Also, it will be useful to consider how the proposal for the marrying up of the demands of the professional and academic worlds, through the teachers performing the role of an educational facilitator, can contribute to the development of the Faculty's Human Resource Management Strategy.

A clearly defined role would permit the setting of criteria by which the performance of nurse teachers can be judged. It would also allow for the development of a coherent staff development programme to meet the teachers' academic, as well as their professional needs, which could be matched to the organisational objectives. The Faculty, by introducing the proposal of each teacher working one day per week in practice settings could allocate, on a more equitable basis, a work load to nurse teachers in the delivery of all aspects of the curriculum. It has been demonstrated in this piece of research that the role of an educational facilitator is acceptable and

workable in all practice settings therefore, it should permit nurse teachers to work across the institutional/ community divide. Teachers in the Adult and Child Branches need no longer be confined to linking with institutional settings and therefore, the number of practice placements to which each teacher is linked can be allocated on a more equitable basis. The Faculty could then be assured that all teachers would be available for the remaining four days per week for all other curricular activities, such as classroom teaching, setting and marking scripts, the pursuit of research etc.

I perceive that an advantage for the nurse teachers of having a clearly defined role in practice in practice settings, to which one day per week is timetabled into their working week, is that this should help to reduce the role conflict which they said arose from the lack of role clarity. The defined role of an educational facilitator would permit the teachers to link with each of their areas on a rotational basis, and to spend an equitable amount of time in each area. Once the role has been established in each of the areas, it should not be necessary for the nurse teachers to spend the whole of one day in each of the areas. The teachers would have the benefit of being aware of any changes taking place in practice and could then ensure that their teaching was based on contemporary practice and would be able to identify any practice updating opportunities available to them. To the purchasers of education, I perceive the benefits to be that, they would be assured that quality assurance mechanisms were in place to ensure that student nurses' education and training produced competent practitioners. Because the Faculty would be demonstrating their commitment to linking nurse teachers to practice areas for one day per week, the practitioners would be assured of the support that they could expect in relation to their responsibilities for teaching and assessing student nurses. They would also be assured of being updated on a regular basis about any changes to the curriculum or assessment procedures and also on any research relevant to their areas of practice.

For the student nurses, I perceive that they would have the major benefit of undertaking practice placement experience in areas where the practitioners have an up to date knowledge about how best to meet their learning needs and would therefore, be in a better position to link theory to practice.

At the time this research was concluding, the structure of the Faculty had not been established and consequently, I am not in a position to implement the proposed role across the whole of the Faculty. I have therefore produced the protocol, outlined below, for the performance of the new role which I will present to the Faulty's Management Executive Group for their consideration. I would suggest that the adoption of the protocol will make "public" (Goode 1966, p314) the Faculty's commitment to the delivery of quality educational programmes.

(ii) Proposed educational facilitator protocol.

As a provider of quality education, the Faculty aims to promote and maintain a positive learning environment in practice settings, in order to enable students on programmes, to take full advantage of the wide learning opportunities and experiences available to them, in placement areas. This is achieved through continuous liaison with and the maintenance of effective communications between practitioners and teachers. The practitioners working within the placement area are the major influence upon the quality of the learning environment. It is within this context that supporting the ongoing professional and educational development of these practitioners is seen as the primary process by which the educational facilitators will achieve their goal.

The primary purpose of the educational facilitator role is to support the development, maintenance and improvement of an appropriate learning environment for students within the placement area(s) to which the teacher links, and to contribute to the identification of the professional needs of staff within the placement area.

The educational facilitator role is integral to the Learning Environment Audit process and the ongoing support and development for placement areas. Also for the audit of the learning environment to ensure the area can be supported in maintaining the required standards to remain a placement area for students. The time spent in practice areas would also allow for the supervision and support of students, especially at times of difficulty, and for teachers to maintain and develop their professional knowledge founded on contemporary practice.

Proposed time element.

It is recommended that the necessary working conditions be made available to teachers and therefore, when determining the assignment of teachers' duties and determination of their academic work loads, that time be allocated to this role. For full time staff, it is recommended a minimum of 7.5 hours per week be allocated for the purpose of the educational facilitator role, and for part time staff an equivalent minimum amount proportional to the number of hours worked.

Reflections on the action research process.

I chose an action research approach as the process by which to carry out the study as suggested, by Reason & Rowan (1981, p57), this approach is part of the new paradigm of research which holds a different philosophical perspective from more traditional research studies. New paradigm research is concerned with doing research with and for people, rather than on people. It supports the notion that the advancement of science and the improvement of human welfare is best achieved by devising strategies in which research and actions are closely linked. Such studies, therefore, involve practitioners in the field and, in this instance, it was nurse teachers and practitioners, who identified their practical concerns and "explored ways of overcoming issues within the murky waters of reality". As Meyer (1995) suggested, action research seeks to involve practitioners in the creative thinking that goes into a research enterprise by giving opportunity for participants to act as co - researchers by contributing both to the action, which is the subject of the research, and to the methods of inquiry.

Unlike more orthodox forms of research which may or may not lead to change in practice and social improvement, such a collaborative inquiry is seen to be a form of education, personal development and social action (Reason, 1988, p19). Each study is unique as they have no hypothesis or predicted outcomes and therefore follows its own pattern of development as it emerges in collaboration with participants, in the reality of practice. However, important lessons can be learned about the stages of action research by reflecting on an individual's experience of

the process in practice. This dissertation represents one such activity.

(i) Development of reflexivity.

My choice of action research, as the methodological approach, has enabled the drawing together of the various strands of the research process, reflection on my own practice as a manager and the development of reflection in both the teachers and practitioners through the use of reflective diaries. Webb (1990) identified her belief in action research as a valuable technique for introducing and evaluating change within a practice discipline, because it encourages an openness, self criticism and reflexivity among all participants. Therefore through the use of an action research approach to my study I have endeavoured to be reflexive whilst writing up the report.

(a) What is meant by reflexivity ?

Rogers (1983) argued that the development of reflexivity "concerns those practices that simultaneously describe and construct a social setting", specifically in relation to research. It involves the realisation that researchers are part of the social world they study. Rather than engaging in futile attempts to eliminate the effects of the researcher, reflexive researchers try to understand them (Hammersley & Atkinson 1983, p15). Gouldner (1971) explained that reflexivity entails researchers viewing their own beliefs in the same fashion as they view those held by the subjects. This then requires an honest examination of the values and interests that may impinge upon research work. This view was reiterated by Clarke et (1993) when arguing that action researchers accounts should be reflexive; that is they should explain how researchers influence the research.

Gouldner (1962) has argued that value - free sociology is a myth designed to allow sociologists

to be morally indifferent and thus to escape from the implications of their work. Researchers claiming to adopt a value - free stance can be accused of failing to reflect upon the position of others. Objective disinterest leaves little room for self - criticism, or even debate within the research community. Hammersley (1990) explained that if the values and relevance that shape data are not recognised by the researcher, they will be even more obscure for the reader. This lack of explicitness makes it extremely difficult to assess the validity of studies which purport to be free of researcher influence.

Abbott & Wallace (1990, p3) wrote that research must be genuinely reflexive - that is, the accounts of the research must be available to the reader and explain the way in which the knowledge was produced out of the research, and describe the experience of being a "researcher". Porter (1993) argued that the first step towards reflexive nursing research is acceptance that the person of the researcher is an integral factor in the production of the research. A reflexive approach encourages researchers to explore and consider how they construct and interpret data and to be critically aware of how we reach our conclusions. Reflexivity, therefore, is inseparable from the research process.

<u>(b) What is the relationship and overlap between reflection and reflexivity ?</u>

Powell (1989) suggests that "reflective practice" has commonalities with the concept of reflexivity, even though it appears to maintain the subjective/ objective dichotomy (Mezirow 1981) that reflexive theory regards as so unproductive. Dewey (1933, p31) whose definition is one of the earliest and most quoted definitions saw reflection as "active, persistent and careful consideration of any belief or supposed from of knowledge in the light of the grounds that support it and further conclusion to which it tends".

Emden (1993, p336) explained that observation and reflection within the context of inquiry mean, seeing, hearing, and sensing events within your practice world and pondering their meanings, with a view to action. By engaging in observation and reflection it is possible for all preconceived ideas to be challenged, including principles, theories, policies and "right" ways of thinking and behaving. Reflecting on our experience builds concepts which are then tested through experimentation and experience and so on (Schon 1983, p50). Schon identified this process as a learning process.

Authors, such as Boyd & Fales (1985) and Bould et al (1985) considered the process of reflection as involving the self, and the outcome of reflection as a changed conceptual perspective. They also considered that it involves the ability to recognise and recollect accurately salient events and key features of an experience and to give a comprehensive account of the situation. Bould et al (1985) acknowledged that reflection can occur by describing thoughts in a diary whereas reflexivity goes beyond the stage of description, it involves the writer acknowledging the influence that they can bring to bear on a situation being studied (Gouldner 1971).

Stanley (1990, p3) in her description of the analytical approaches used in Studies of Sexual Politics refers to conscious reflexivity in that, rather than simply acknowledging the researcher's active role, reflexivity encourages a close analytical attention to the details of that process. Rather than describing at a general level "the research" before getting down to the serious business of discussing 'findings' and their relationship to 'theory', the intention is to draw the process of knowledge production, in research and theorising, into its product in the shape of written accounts about it.

Bannister (1991) suggested that reflexivity is at the heart of personal construct theory. This implies that the questions involved in research have personal meaning and significance for the researcher. As a researcher engaged in observation and reflection, you are encouraged to take up the concept of reflexivity, recognise the personal significance of the task before you and resist the temptation to view colleagues as "subjects" when observing them in practice.

Therefore, in this piece of research I have been studying a world of which I myself have been a part, with all the emotional involvement and accusations of subjectivity that this creates. I have not attempted to keep my colleagues at arm's length to have done research 'on' whilst maintaining a dominant position, as is common in much 'objective' research. My research has been a two-way process of interaction and sharing between myself and teachers and practitioners. I have attempted to be reflexive and have explored my perceptions of how I have influenced the research process when writing up the dissertation.

(ii) The manager/ researcher relationship.

Meyer (1993) highlighted that collaboration implies equality of relationships between researcher and participants which theoretically is not present in other forms of research. She suggested that a collaborative approach assumes that research is done with and for people rather on people but questioned to what extent this is possible in reality. Although working collaboratively, there were times when I wondered if the participants perceived me to be in the role of a researcher or of a manager, because of the power relationship between us. As a manager, new into post, I found that an action research approach allowed me to work collaboratively with the teachers to find a solution to their problem, and this proved to be an ideal method for building up a working relationship with them. The mutual collaborative approach enabled us to work together on their problem and, through ongoing dialogue we were able to arrive at a shared understanding

of a proposed role for them in practice settings. Also it allowed us to agree a way forward to trial the role and initially to agree the process for the implementation of it in all practice settings.

However, on several occasions throughout the research I perceived that the participants in the research were conscious of the power relationship between us. This was particularly evident in stage three of the research when they were required to record their reflections on the performance of the proposed role in practice and then to post these recordings to me on a regular basis. Because of the tardiness of some of the participants to perform these tasks I had to, in my role as a researcher, remind them to fulfil their agreement. Conscious that I was working to a time scale I, want to proceed with the analysis of the recordings and complete the research, but I felt that they perceived they were being pressurised by "the manager" as opposed to "the researcher" to complete the reflective diaries. This, I would suggest, raises the very important question as to whether there can be a truly collaborative approach between managers and those being managed.

The issue of power also arose at the implementation stage of the identified role. Although the teachers had collaborated in the research to identify and trial a role for themselves in practice settings, I felt that they subsequently saw me primarily as "their manager" who should take responsibility for the implementation of the findings, as opposed to "a researcher". They saw me as having the responsibility for advocating on their behalf when the major changes in the culture of the organisation were taking place. Waterman (1995) suggested that there is an emancipatory element to action research which is reflected in the process since there is a desire to develop or change people's lives so that knowledge is not merely sought for "its own sake" but as means to social improvement. The teachers within the College (Faculty) have identified an agreed role in practice as the means of changing their working lives but at the present time,

because of the formulation of the new Faculty, they are not in a position to implement the findings.

(iii) Structural power in the organisation.

The fact that we, the research team, are not in a position to implement the role has been found to be a source of frustration. Cope (1991, p143) advised that an important issue which needs to be taken into consideration in relation to the successful implementation of change is "that those that are likely to be successful will have to incorporate power from the relevant authorities and the necessary sanction to control and acquire resources". At the commencement of the research, power had been invested in me by the College's Directorate Management Group, to conduct the research and to implement any recommendations arising from the research, which included the necessary resource allocation for this purpose. Following the integration of the College into the University I no longer have the power to implement the findings but can only make recommendations to the Faculty Executive Group.

Weiss (1982, p298) when writing on the impact of social science research and public policy making identified that, the people holding the top positions have the authority to come to a decision to see that any policy making decisions are implemented. But she also pointed out that, rarely does research supply an "answer" that policy actors employ to solve a policy problem, whilst changed discourse is likely to result eventually in new modes of action, the process may be agonizingly slow and inexact. Also the policy action which finally emerges cannot be expected to correspond closely with the preferred state envisaged by the social scientist.

The sentiments which were quoted by Weiss are reflected in the most recent concerns expressed by nurse teachers in the College in that, the debates within the Faculty on the role of nurse

teachers in practice settings have been ongoing for almost a year. They expressed their concern that, the outcomes of their action research project have, as yet, not been taken into consideration in the Faculty Executive Group's debates. The teachers fear that, any decision reached by the Faculty Executive Management Group, on the role for nurse teachers in practice settings may not be one that is acceptable to them.

This raises the question of effective management support in managing change and whether action research is, in fact, an effective tool to bring about organisational change when there is an overall change in the philosophy of an organisation. Dadds (1995, p16) raised the possibility that, small scale action research is not valued at a structural level. This could be the reason why the Faculty Executive Management Group may not have consulted the research team during their deliberations on a role for nurse teachers in practice settings.

(iv) Limitations to the study.

In order to attempt to define a role for nurse teachers which was acceptable and workable in all areas of practice, I considered it necessary to gain the views from representatives from a whole range of practice / teaching specialities, and as a result a total of twenty four teachers and twenty four practitioners were interviewed using a semi structured questionnaire in the planning stage. This number of respondents proved to be very large and because of the number involved I decided to record the interviews by hand as opposed to taping them. Whilst I accept that the tape recording of information is probably considered to be more reliable than recording responses by hand however, as pointed out by Baker et al (1992), only the participants can validate their statements. And as suggested by Brinks (1991, p121) further validation may occur when others reading the study recognise their own experience and can say "Oh, yes!, that's exactly what happened to me". The presentation of my research to other members of the Faculty will allow

for this process to occur. I, personally addressed the issue of validity by discussing each participants interview with him / her in conjunction with my transcript of their interview. A copy of their own transcript was handed to each of the participants.

The study was undertaken mainly on one site of a College of Health which has subsequently been integrated into a newly formed Faculty of Health and Social Care of an institution of Higher Education. Initially the practitioner, student nurse and teacher sample group, although broadened out slightly, was representative of that one area of practice. Therefore the validity of the study may be of specific relevance to only this campus, and not to the Faculty as a whole which was formed from three different cultures. Therefore generalisations cannot necessarily be drawn from the findings as a result of these limitations. But as Meyer (1993) suggested, normally, the researchers themselves do not implement change but, generate findings and feed them back to the organisation to encourage discussion. Therefore my findings will be disseminated to members of the Faculty Executive Management Group to enable them to make decisions about what changes are needed as well as when, and by whom, action will be taken. My findings will also be disseminated to others in authority in the University, the Faculty and Managers of the local NHS Trusts for their consideration. Highlights from the research will be distributed to all nurse teachers in the Faculty and the practitioners who participated in the research.

The opportunity for discussion throughout the Faculty will help to validate the findings, as Hycner (1985) suggested, the researcher needs to submit the findings to the "lay community", through the initiation of a wider dialogue whereby the findings can be discussed and evaluated from a larger number of perspectives and either be accepted, modified, or rejected as necessary. The teachers and practitioners taking part in this research were able to concur that the findings

are valid for them, but as they now represent only a small sample group of the total population of the new Faculty, it would be useful to have an opportunity to widen the debate beyond this group of participants. Also to have the opportunity to pilot the role across the wider arena.

A lesson learned from the process of carrying out the research was that it is necessary to ensure that all participants are fully informed of the purpose of each stage of the research, as this was an omission at the piloting stage of the agreed role in practice settings. I dealt with the managers of each practice area in anticipation that they would inform their staff in their practice areas but this did not prove to be the case in all areas. Although I sent a copy of the role specification to the person in charge of each of the practice areas, it was not shared with all of the staff members, and therefore some confusion did arise because of this. Therefore, before moving onto cycle two of the research I would need to ensure that all practitioners were fully aware of the purpose for the teachers being in their area of practice. One benefit arising from the teachers collaboration in the research process is that in subsequent cycles the thirteen teachers who were involved in the piloting of the role will be able to assist me to clarify with all parties the purpose of each stage of the research.

<u>The contribution of this piece of research to the theory and practice of nursing.</u>

McFarlane (1977) reminded us that nursing is a practice discipline and therefore any theory of nursing must be ultimately related to practice. She stated that theory grows out of practice. One observes and clarifies nursing experience, and develops nursing concepts. Concepts play an important role in the development of knowledge promoting the organisation of experience and facilitating communication about phenomena. Sims (1991, p60) reminded us that the aim of theory is to enhance our understanding of, and to guide nursing practice. She suggested that, the practitioner who is immersed in the reality of nursing and who brings existing practice to

conceptual awareness (through reflecting on practice, for example), develops theory which has direct relevance to practice.

Although there have been many studies on the role of the nurse teacher in practice settings, this piece of research widens the concept by analysing and defining a locally acceptable role, and then through using an action research approach evaluated the role in action.

The majority of the recorded research studies into the role of the nurse teacher in practice settings appear to have been undertaken in the field of Adult (General) Nursing in Acute Hospital settings. This piece of research has examined the enactment of the role of the link teacher in a whole range of practice placements in order to determine whether, it was possible to derive a consensus view on a "defined" role which was appropriate in all areas of practice. The "model" which has emerged from this piece of research, with teachers performing the role of an educational facilitator, has been evaluated as effective in practice. In this context, this aspect of the research adds to the theory and practice on the role of the nurse teacher in practice settings.

Sims (1991, p63) also argued that, if a theory is to be useful for practice, it must be valid. That is, it must provide evidence of accurately representing the reality of nursing. This research, which was undertaken on the performance of a role for nurse teachers in practice settings was set in the context of the introduction of Government and Statutory policies which impinge upon, and create demands upon nurse teachers' time and commitments. I would therefore, suggest that this piece of research accurately represents the reality of nurse teachers attempting to cope with the tensions between the worlds of academic and professional practice. Sims (1991, p61) also suggested that stronger links between practice and theory could be achieved through the

implementation of strategies to bridge the education and service sector. I would suggest that, this piece of research has demonstrated that nurse teachers working in the role of an educational facilitator fulfils this expectation.

Gray and Forsstrom (1991, p371) highlighted that reflective practice provides a rich source of data for nurses wishing to contribute to the theoretical development of the discipline of nursing. Writing about the experience of nurse teachers developing and evaluating a defined role in practice settings is an effective means of sharing with other nurse teachers the process of developing and implementing the reflective technique. It is hoped that this sharing will help other nurse teachers to structure their working methods in practice areas.

Important issues arising from the research.

(i) Teacher preparation.

Arising from the research it is evident that the debate regarding the role of the nurse teacher in practice settings is not new. The demise of the clinical teacher role and the introduction of one grade of teacher without a role specification by the Statutory Bodies has resulted in a failure to identify the clinical role expectations for nurse teachers at a national level. Exploration has shown that there are no national guidelines and no consensus within the nursing profession itself as to its expectations for a role for nurse teachers in practice settings.

The research has also highlighted the inadequacy of preparation courses for nurse teachers to prepare them for an expected clinical role. The Statutory Bodies, whilst recommending that there should be a review of nurse teacher training courses so that they adequately prepare them for both a clinical as well as a classroom teaching role, have yet to come forward with any recommendations on the way forward. The inadequacy of preparation courses for nurse

teachers, I would suggest, contributes to the problem, as opposed to providing answers to the role and function of nurse teachers in practice settings.

(ii) Teachers ongoing professional development.

The UKCC (1986 p12) and the ENB (1993 section 2) recommended that nurse teachers should be "engaged in practice" and "be able to teach theory and be able to link that theory in practice", and yet at the same time have produced no guidelines on how they expect this to be achieved. Nor have they produced any guidelines on how nurse teachers can maintain their clinical skills in an ever changing world brought about by the implementation of national policies at a local level.

With the introduction of Project 2000, the nurse teachers' main emphasis for their own ongoing development has been on the preparation for the delivery of new theoretical concepts. With the lack of guidelines from the Statutory Bodies on the necessary ongoing development of nurse teachers, it is almost inevitable that the teachers have gone down the road of seeking academic qualifications to the detriment of clinical updating.

Bowman (1979) highlighted the importance of the ongoing development of the nurse teacher and the need to identify a strategy to achieve this. But, as with initial teacher preparation, no national strategy has been produced. Indeed, as identified by Crotty and Butterworth (1992), an important component of ongoing professional development of nurse teachers is the resourcing of such an activity but this is also yet to be identified. It is little wonder that, both Colleges of Nursing / Health and, nurse teachers themselves, find themselves in a position of conflict between the Institutions of Higher Education, who have the autonomy in matters of resource allocation, and the Statutory Bodies who, whilst stating their requirements for the clinical

involvement of nurse teachers, do not supply the resources for such activities.

The inter relationship between the nurse teacher performing the role of an educational facilitator to their on ongoing professional development, under PREP requirements (UKCC, 1994), has been identified within this piece of research. The ongoing contact with the practice areas would allow them to update themselves appropriately for compliance under PREP requirements. The nurse teachers, whilst acting in the role of an educational facilitator, were not only able to update their own knowledge relevant to their area of speciality but also as a result were seen as "credible" by the practitioners.

Recommendations arising from the research.

At the time this research was concluding, the structure of the Faculty had not been established and consequently, I am not in a position to implement the proposed role across the whole of the Faculty. In addition, debates continue within the Faculty about the role of nurse teachers within practice settings and therefore, I am making the following recommendations to the Faculty Executive Committee for their consideration that:

* the role of an educational facilitator, outlined on p114, be considered as a suitable role for nurse teachers in practice settings and that the role be further trialled across the Faculty

* the proposed protocol, which involves time allocated to nurse teachers to perform the role as outlined on p126, be adopted by the Faculty.

* the protocol be made "public" (Goode, 1966, p314) thus demonstrating the Faculty's commitment to the delivery of quality educational programmes.

Recommendation to the wider audience

Teachers and practitioners in this College (Faculty) of Health have identified a suitable role for nurse teachers in practice as that of an educational facilitator. They have reported that this role which is effective in all practice settings and enhances the delivery of the curriculum in practice. But it must be recognised that it is a solution based on local issues and problems, so the findings are limited in their ability to be generalised. However, an action research approach is recommended for use in other Colleges of Health which are also grappling with the same problem of identifying a role for nurse teachers in practice settings.

Suggestions for future research - cycle two.

This valuable piece of research has come up with useful findings, and those involved are motivated to carry it forward and have plenty of ideas of what to do next.

The role of an educational facilitator has been evaluated, by a sample group of nurse teachers and practitioners, as one which they perceive to be effective in closing the theory/ practice gap. As the role was still evolving, I did not consider it appropriate to involve student nurses at that stage in the evaluative process and therefore, in cycle two it will be necessary to address this issue. It will be important to ascertain the views of student nurses who have undertaken practice experience in the placement areas where the teachers have piloted the role. This will establish whether they, in fact, perceive that a gap still exists in the curriculum delivered by this College. Also to ascertain the students' views on the effectiveness of the new nurse teacher role and then to make any refinements, as necessary.

The study was undertaken on one site of a College of Health which has subsequently been integrated into a newly formed Faculty of Health and Social Care of an Institution of Higher

Education. The teachers and practitioners taking part in this research were able to concur that the findings are valid for them, but as they now represent only a small sample group of the total population of the new Faculty, it would be useful to have the opportunity to widen the debate. Also to have the opportunity to pilot the role across the wider arena in order to evaluate any further benefits which may be derived from nurse teachers performing the role of an educational facilitator. The nurse teachers and practitioners participating in the research did not suggest amendments to the identified elements of the role of an Educational Facilitator, and therefore the opportunity to further examine these elements would be welcomed.

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Nightingale (1860) defined nursing as a process to put "the patient in the best position for nature to act upon him", and I would suggest that the process of teaching nursing is to put "the student in the best position for the educational processes to be effective for him" and that by acting in the role of an educational facilitator in practice settings, the nurse teacher would be fulfilling that function.

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APPENDICES

APPENDIX 1.

Outline of policies and the effect of their implementation.

Date	Policy	Effect of policy implementation
May 1990	Introduction of Project 2000 into the Schools of Nursing and the formation of a College of Nursing	Necessity for teachers to demonstrate the integration of theory and practice. Requirement for increased theoretical input to the course and an exit at least at the level of Diploma of Higher Education
May 1992	Completion of the formation of the College of Health	Hospital Schools of Nursing close thereby creating a geographical distance between the College and the Hospitals
1992 onwards	Skill mix reviews in N.H.S. Trusts and the employment of health care assistants	Reduction of the number of Registered nurses employed causing conflict between delivery of patient care and teaching and assessing both student nurses and H.C.A.'s
1992 onwards	Requirement for nurse teachers to gain graduate status	At the height of the activity the equivalent of 7 F.T.E. teachers away on any day of the week
January 1993	Business culture enters the College of Health	Gradual reduction of the number of nurse teachers employed
March 1994	IDENTIFICATION OF THE PROBLEM AND COMMENCEMENT OF RESEARCH STUDY	
October 1995	Integration of the College into Higher Education	Clash of cultures - professional versus academic (clinical updating of nurse teachers v writing for publication and undertaking research). And linking with another College of Health to form the new Faculty
February 1996	COMPLETION OF THE RESEARCH STUDY	

TEACHERS INVOLVEMENT IN TEACHING IN PRACTICE SETTINGS.

Issues for debate

1. What is understood by teachers "credibility ?

2. What constitutes "teaching" in the practice placement areas ?

3. What is the interpretation of **"the equivalent of one working day per week"** in practice settings in relation to:

   (i) the number of wards allocated to each teacher

   (ii) the geographical spread of placement areas

   (iii) is it achievable ?

4. What is understood by the theory / practice gap ? and does it exist ?

M. Williams Vice Principal, Pre-Registration Nursing Studies 16/03/94

Student Nurse Questionnaire.

1. Which term of training have you just completed ?

2. What is your chosen branch ?

3. What is the nature of the clinical speciality that you have just undertaken ?

4. What was the length of the experience ?

5. At this stage of training what are your expectations for support from the link teacher in the practice settings ?

6. In what way has the link teacher supported you in your last practice placement ?

7. Whose responsibility do you consider it to teach you in the practice settings ?

8. Why do think this ?

9. In this practice placement, who has given you the most teaching support in the day to day care of patients ?

10. Are there any differences between what you are taught in the College and what you experienced in this practice placement ?

11. If so what are the differences ?

12. Can you suggest how these differences can be reconciled ?

13. Have you any other views on teaching in the practice settings ?

Nurse Teacher interview schedule.

1. How long have you practised as a nurse tutor?

2. Were you previously employed as a clinical teacher?

3. What was your clinical area of expertise prior to becoming a clinical teacher / nurse tutor?

4. How frequently do you visit the practice placement areas ?

5. What determines the frequency of your visits to the practice placement areas ?

6. When you visit a practice area what is the average length of time spent in each area ?

7. How many clinical placement areas do you have responsibility for ?

8. What speciality areas does that involve?

The E.N.B. Regulations and Guidelines Relating to all Courses (para 3.2) states " as nursing and midwifery are practice based professions, it is essential that the teachers are enabled to remain engaged in practice. Therefore these teachers should be involved in teaching in practice settings for the equivalent of one day per week.

9. Do you agree with this statement ?

10. What does this statement mean to you ?

11. Can you suggest how teaching in the practice settings can be put into practice ?

12. What conditions exist which militate against your expectations ?

13. What conditions exist to facilitate your expectations ?

14. Whose responsibility do you consider it be to teach in practice settings ?

15. Why do you think that ?

16. Do you consider it necessary for teachers to be updated in clinical practice ?

17. If so - how do consider that this is best achieved ?

18. The theory and practice of nurse education is continuously evolving ; are there any aspects of nursing theory or practice which you currently teach that was not practised prior to your entry into nurse teaching ?

19.How did you update your theoretical knowledge/practice to teach these topics?

20. What do consider the role of the teacher to be in practice settings?

21. Many authors suggest that there is a theory /practice gap in nursing ie. a difference between what is taught to student nurses in the College of Nursing and what is experienced by them in the clinical settings. What are your views in relation to this statement ?

22. If there is a theory practice gap can you suggest how this can be remedied ?

Practitioners Interview Schedule

1. How long have you been a Registered Nurse ?

2. What is the speciality of this practice area ?

3. For how long does the student nurse come to your practice setting ?

4. What do you consider the role of the link teacher to be in your practice area ?

5. What are your expectations in terms of the input from link teachers into teaching student nurses in your practice area ?

6. Do you consider it necessary for link teachers to be clinically up to date in the practice area ?

7. If yes, can you suggest ways in which link teachers are enabled to update clinical competence

8. Whose responsibility do you consider it to be to teach in your practice area ?

9. Why do you think that ?

10. Many authors suggest that there is a theory /practice gap in nursing ie. a difference between what is taught to student nurses in the College of Nursing and what is experienced by them in the practice settings. What are your views on this statement ?

11. Can you suggest how the theory/practice gap can be remedied?

12. Have you any other views on teaching in the practice settings ?

ROLE COMPONENTS OF AN EDUCATIONAL FACILITATOR

Although the nurse teacher will retain the responsibility for student support, the main emphasis of the role in practice settings is to strengthen the relationship between theory and practice. This will be achieved through the facilitation of practitioners in their educational role and by enhancing the practice learning environment in support of student nurses.

Student supporter.

(i) act as a supporter/ teacher
(ii) act as a role model by demonstrating appropriate attitudes and professionalism
(iii) ensure that each student is aware of what is expected of them
(iv) assist students to value each clinical placement
(v) assist students to link theory to practice
(vi) act as a clinical teacher (as appropriate)
(vii) give guidance on written assignments relevant to practice area

Practitioner facilitator,

(i) communicate the nature and level of students' education and training requirements
(ii) assist practitioners to create teaching opportunities
(iii) update practitioners on changes to the curriculum/ assessment
(iv) assist with student assessment
(v) update practitioners on research relevant to their area
(vi) give guidance on the support of students in their clinical area
(vii) advise on up dating opportunities
(viii) encourage clinical staff to participate in teaching activities in the College
(ix) encourage use of reflective practice
(x) provide support to practitioners who are experiencing problem with students

Enhancer of the practice setting environment,

(i) be conversant with the activities in the area
(ii) ascertain the learning opportunities available to the students and jointly agree with practitioners appropriate learning outcomes
(iii) act in a quality assurance role by preparing clinical areas for audit, undertaking the audit and monitoring the implementation of the recommendations arising from the audit

Enhancing curriculum design and delivery,

(i) feed back information into the College on any changes in the practice areas which affects the delivery of the curriculum

It is envisaged that by performing the proposed role the link teachers would be **teaching in** the wider context by helping clinical staff to develop an educational environment. Thus the clinical staff would be better equipped to support students. The link teachers would be **keeping up to date with what is happening in practice.** The successful implementation of any new agreed role would be through increased channels of communication between the link teacher and the clinical staff so that they have a better understanding of each others' work and how best they can support each other.

MEMORANDUM

To: All Tutors
Senior Education Managers

From: Maggie Williams
Acting Principal

Date: 17th. March 1995

<u>An investigation to identify the Role Determinants and Characteristics of the "link teacher" in clinical practice settings.</u>

As you are aware I am undertaking a research study into the role of the link teacher in clinical practice. This, I felt was necessary because currently there is no defined remit for the performance of that role within this College. Therefore, teachers, students and clinical staff are unaware of what is expected of the "link teacher".

The research study has identified a **consensus** view of the role of the "link teacher" as **"a facilitator of education" in the clinical environment.**

Since the distribution of copies of the original proposed role in January, the English National Board has updated its' Regulations and Guidelines for Training (January 1995). These amendments require defined activities to be undertaken by the nurse teacher in clinical settings, vis a vis paras :-

2.5 Liaison should include discussion with the qualified staff about the relationship between the theory and practice and the use of relevant assessment documents

2.3.12 if there is cause for concern during a placement, accounts of discussions held between the student, assessor and link teacher must be recorded in the assessment documentation and entered in the portfolio

2.3.13 Where there is cause for concern the link teacher must facilitate the agreed action.

9.5.2 Education and service managers together must ensure that adequate and appropriate teaching and supervision will be available to the student

9.5.5 In addition all those involved with the programme should be familiar with the programme structure, organisation and content

The proposed role has, therefore, been refined to take into account the above E.N.B.'s requirements. It should ensure that there is an understanding between nurse teachers and clinical staff of the role of the link teacher. The role, as outlined, is as a **facilitator of educational processes**, it is not prescriptive in all aspects. Those staff who wish to deliver "hands on care" or to "work with students" are not precluded from doing so.

In order for nurse teachers to be able to maintain their clinical links and undertake a formalised role once we have integrated into Higher Education, I will be suggesting that clinical contact hours are included in the total student contact hours. Clinical contact in this sense has as much to do with supporting clinical staff as it does with supporting students' training. This significantly contributes to the development of the learning environment and enhances the students' experience.

It is important that we have a defined role established for the link teacher before we go into Higher Education otherwise it maybe difficult to negotiate it afterwards. I wish to trial the proposed role so that it can be refined as necessary. I am therefore seeking volunteers to trial the proposed role to test whether it can be adopted formally as the agreed way forward. If you are willing to participate in the trial, I would be grateful if you could contact me so that we can discuss the implications for your involvement.

Thanking you in anticipation.

NAME:

REFLECTION ON PRACTICE PLEASE RECORD HOW THE DEFINED ROLE HAS

CHANGED YOUR PRACTICE IN THE PLACEMENT AREA

CHANGED YOUR WORKING RELATIONSHIP WITH THE PRACTITIONERS

AFFECTED YOUR DAY TO DAY WORK IN THE PLACEMENT AREA

IMPROVED YOUR PRACTICE

DO YOU PERCEIVE ANY DISADVANTAGES TO CARRYING OUT THE ROLE OF AN EDUCATIONAL FACILITATOR ?

PLEASE REFLECT ON YOUR EXPERIENCE IN CARRYING OUT THE DEFINED ROLE OF AN EDUCATIONAL FACILITATOR

NAME: NAME OF LINK TEACHER:

REFLECTION ON PRACTICE PLEASE RECORD HOW THE DEFINED ROLE HAS

CHANGED THE PRACTICE OF THE LINK TEACHER

CHANGED THEIR WORKING RELATIONSHIP WITH THE PRACTITIONERS

AFFECTED THE DAY TO DAY WORK OF THE LINK TEACHER

ASSISTED THE PRACTITIONERS TO ACQUIRE A BETTER UNDERSTANDING OF THE NEEDS OF STUDENT NURSES

ASSISTED THE PRACTITIONERS TO LINK THEORY TO PRACTICE

DO YOU PERCEIVE ANY DISADVANTAGES TO THE CARRYING OUT OF THE ROLE OF AN EDUCATIONAL FACILITATOR BY A NURSE TEACHER ?

Proposed educational facilitator protocol.

As a provider of nurse education the Faculty aims to promote and maintain a positive learning environment in practice settings, in order to enable students on programmes, to take full advantage of the wide learning opportunities and experiences available to them, in placement areas. This is achieved through continuous liaison and the maintenance of effective communications between practitioners and teachers. The practitioners working within a placement area are the major influence upon the quality of the learning environment. It is within this context that supporting the ongoing professional and educational development of these practitioners is seen as the primary process by which the educational facilitator will achieve their goal.

The primary purpose of the educational facilitator role is to support the development, maintenance and improvement of an appropriate learning environment for students within the placement area(s) to which the teacher links, and to contribute to the identification of the professional needs of staff within the placement areas.

The educational facilitator role is integral to the Learning Environment Audit process and the ongoing practice area monitoring, this produces a link between the two elements of the ongoing support and development for placement areas. Also for the audit of the learning environment to ensure the area can be supported in maintaining the required standards to remain a placement area for students. The time spent in practice areas would also allow for the supervision and support of students, especially at times of difficulty, and for teachers to maintain and develop their professional knowledge founded on contemporary practice.

Proposed time element.

It is recommended that the effective working conditions be made available to teachers and therefore, when determining the assignment of teachers' duties and determination of their academic work loads, that time be allocated to this role, and for full time teaching staff a minimum of 7.5 hours per week be allocated for the purpose of the educational facilitation context, and for part time staff an equivalent minimum amount proportional to the number of hours worked.